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Center for Substance Abuse Treatment

communiqué

A Memo to the Field from CSAT's Treatment Improvement Exchange

Monitoring Treatment Outcomes and Managed Care: Promise and Challenge for the AOD Field

Our treatment practices can become ever more effective as we learn more about how much and what kind of treatment interventions offer the most long-term promise for different types of clients.

special issue

Today, the substance abuse field faces a political and fiscal climate in which publicly funded services are being closely scrutinized and tightened. The American public, Congress, and State legislatures all demand proof that their public dollars are being spent effectively. The future of the substance abuse field, and our ability to provide quality care for public clients, hinges on how well we can meet this demand. For us, accountability translates into increased — and more sophisticated — monitoring of treatment outcomes. Our monitoring practices need to be assessed and refined at all levels — from State AOD agencies to regional and county agencies to treatment providers.

All of us who work in the substance abuse field *know* that treatment is effective. The challenge now is to identify how much treatment and what components of treatment are most successful with which clients in what phases of addiction. We need to know the minimum amount of treatment that will produce a positive benefit for different types of patients. At what point do client gains begin to taper off? The current push to shorten time in treatment and to provide less residential treatment can have destructive consequences for some publicly funded clients. We need specific outcome data to prevent reductions in treatment that come at the expense of our clients' best chances for recovery.

State substance abuse agencies and treatment providers are already weathering a dramatic change — the shift to managed care. In 1993, CSAT brought State agencies with the most experience in this arena together with other experts to explore issues affecting our clients and our traditional treatment providers functioning in managed care environments. CSAT acted as a catalyst to help States share their experiences and redefine their State agency roles.

Providing substance abuse treatment services to public clients through either Medicaid managed care or other financial arrangements has turned out to be a complicated task for State AOD agencies, with no single model fitting the varied circumstances in different States. Throughout the CSAT/State partnership, the level of technical training and expertise has been steadily rising, and our mechanisms for handling important issues have been improving. In some States, the SSA now administers the managed care networks responsible for substance abuse treatment.

Like managed care, monitoring treatment outcomes is a powerful new force affecting how we provide and fund substance abuse treatment for our public clients. The ability of States and counties to monitor, and require, certain treatment outcomes will be significant in assuring quality care for public clients, not only those treated through managed care plans but in all other State systems. AOD treatment providers must be able to monitor their program

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interventions in conjunction with their clients' clinical outcomes.

CSAT will work with States to develop mechanisms to enhance and monitor treatment outcomes. Budgets are limited, funding streams and organizational structures are changing, and there are increasing demands that publicly funded treatment programs be guided and justified by measurable outcomes. Over the next few years, the treatment field needs to develop flexible mechanisms that can be adapted to a State's particular situation and the requirements of its organizational and financing arrangements.

This emphasis on measuring treatment outcomes can greatly benefit our field. Our treatment practices can become ever more effective as we learn more about how much and what kind of treatment interventions offer the most long-term promise for different types of clients. We at CSAT welcome your suggestions about how we can assist States and providers in this endeavor.

We have already undertaken these initiatives:

- Two treatment outcomes planning meetings, attended by a volunteer group of State agency directors. Their recommendations provide a framework for State performance outcome measures and policies.

- A contract with the Institute of Medicine, National Academy of Sciences, to convene an expert committee to assess the current state of quality assurance for managed behavioral health care networks. The committee defined key elements to be addressed in performance measurement and accreditation standards for these organizations and health care plans.

- Contracts awarded to 14 States to pilot test different strategies for monitoring the impact of AOD treatment. These different State approaches, described in this issue, should be a rich source of practical experience. CSAT will be disseminating the findings to other States as they prepare to develop outcomes-based monitoring systems.

CSAT expects to provide technical assistance to States that request help with planning new performance and outcomes monitoring systems. Through meetings, workshops, and other methods, we will also help States and provider networks share their expertise on important issues related to outcomes monitoring, such as how to contract with managed care organizations and design State management information systems. CSAT is planning a number of technical assistance documents and workshops on managed care topics where outcome measures are an integral concern.

CSAT thanks all of you who are working so hard to improve treatment services and to ensure that our clients in the publicly funded treatment system continue to receive appropriate care and a continuum of treatment. Thanks also to those who contributed their expertise to this issue of the *TIE Communiqué*.

TIE Communiqué

A Memo to the Field from the Center for Substance Abuse Treatment (CSAT)

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Guest Editorial

Monitoring Outcomes: Our New and Permanent Challenge

— Andrew M. Mecca, Dr.P.H., former Director of the California Department of Alcohol and Drug Programs, also chaired the California Governor's Policy Council on Drug and Alcohol Abuse. He served as president of the National Association of State Alcohol and Drug Abuse Directors from 1993-95. He is currently working with the California Mentoring Foundation.

Those of us in the alcohol and other drug (AOD) field will be dealing with treatment outcomes for the rest of our professional lives. There are three reasons why I make this assertion.

- **Scarce public sector resources.** As money sources tighten, Federal and State legislatures demand greater assurance that we are devoting those resources to the most effective programs.

- **Public demands for accountability.** Two-thirds of all American workers have jobs where part of their pay is based on their performance. These workers are increasingly going to demand that funding be linked to performance in social programs.

- **The ethical focus on client well-being.** Monitoring treatment outcomes is ethically preferable to monitoring what agencies do because it makes client well-being the primary value.

These accountability concepts are much more than the latest management fad. The emphasis on client outcomes as a basis for improving governmental and nonprofit performance is a concept expanding rapidly in ways that extend well beyond the AOD field. Heightened attention to outcomes is apparent across many sectors of U.S. society — in more than half the States, in the implementation of the Government Performance and Accountability Act of 1993, in new work under the leadership of United Way of America, and in work being done by most of the major foundations.

AOD Balancing Acts

For the AOD field, using outcomes at the State and local levels to assess the performance of treatment programs is often a challenge of paradoxes. We need to develop outcome measures and monitoring systems that can satisfy conflicting — even contradictory — forces. We need:

- To pay attention to fiscal and client outcomes simultaneously.

- To phase in the use of outcomes carefully. This measured change will be occurring in a climate of urgency.

- To focus on outcomes for special populations and to set much clearer priorities than ever before.

- To lead from the public sector, while tapping the best that the nonprofit and for-profit sectors have to offer, to ensure that no one sector dominates — that leadership is balanced across all three sectors.

- To develop cross-agency accounting concepts that capture the paradox of cost-offsets. Successful outcomes achieved by an AOD agency often result in major cost savings to other agencies. These savings result from decreased recidivism, fewer child welfare cases, reduced health care costs, and increased employment.

- To market our services and to build constituencies that support AOD prevention and treatment, yet move away from resource allocations driven more by politics than by need.

Each of these paradoxes requires a balancing act. Framing the trade-offs will be a crucial challenge in monitoring outcomes in the AOD field. For example, managed care moves us toward a focus on fiscal outcomes. Yet we have seen that overemphasizing fiscal outcomes — without devoting adequate attention to client outcomes — can lead to a backlash against managed care itself.

In the long term, the best fiscal outcomes are also the best client outcomes. It is only in the short run that the two come into conflict. As one policy analyst put it, "cheaper ain't better." To choose the lowest cost provider — regardless of client satisfaction, the impact on special populations, the well-being of the client's family, or the capacity of the system to deliver services — is to ignore important client issues as though fiscal issues are the only ones that matter.

A second balancing act has to do with reorganization, some of which will focus on the AOD agency. Other reorganization will reflect the need to work across all agencies affected by AOD issues. If agencies don't share concrete outcomes for the clients they have in common, then it will no longer be convincing to talk of "interagency collaboration." Collaboration without the glue of shared outcomes is just a lot of meetings.

Increasingly, State and local AOD agencies will be asked how much money they shifted last year from their least effective to their most effective programs. That clear, simple question is asked annually in the private sector, and any chief executive officer who can't answer it is in trouble. In the public sector, the question is less frequent. But AOD agency leaders who wish to make their own decisions about priorities will need a ready answer. Otherwise, these leaders may

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Public Sector Treatment Outcomes: A Changing Role for County/Local Authorities

— Robert C. Egnew, M.S.W., M.P.H., Past President, National Association of County Behavioral Health Directors, Salinas, CA, and Director, Behavioral Health Division, Monterey County, CA, Health Department

Public policy decisions concerning managed care and welfare reform have important implications for alcohol and other drug (AOD) delivery systems operated by county and local authorities. Many county and local AOD directors are anticipating and evaluating the impact of this reform for their systems. In these new financial environments, there is a great need for outcome measures to evaluate effectiveness and efficiency. One of the key challenges that county directors face is how to define these outcome measures.

What to Measure

Much re-evaluation of public-sector outcomes centers on the issue of what to measure. Will such measures continue to focus solely on treatment outcomes or will they encompass a broader range of performance measures?

Historically, outcomes within public-sector AOD treatment systems have focused on individual clinical successes. These individual outcomes have been measured by rates of abstinence and/or rates of completed treatment. In specific modalities, such as methadone maintenance programs, arrest rates and other indicators have also been used as treatment outcome indicators.

Traditionally, these treatment outcome measures have had a provider focus; that is, they have measured the success of treatment for a particular episode of care with a given provider. Based on these provider-specific abstinence and completion rates, the conclusion generally drawn from this particular set of treatment outcomes is that the longer an individual remains in treatment, the greater the chance of recovery. However, this type of outcome methodology does not address key questions. These questions concern:

- The effectiveness of any specific type of treatment
- The appropriate duration of treatment
- What frequency of services is most effective for a given set of clients

Treatment outcomes featuring abstinence and completion rates are of limited usefulness. Because of this, local behavioral health authorities have used these measures as only one part of their effort to evaluate provider-specific programs.

The Changing Role of County Agencies

With the advent of both managed care and welfare reform, public-sector AOD treatment systems are faced with the task of re-determining their public mission. In the past, public-sector AOD services have suffered from the lack of a concise or pragmatic mission. The field has long been plagued by fundamental questions, such as:

- Who is the public AOD system to serve?
- How are these clients to be served?
- What are the public policy objectives to be achieved?

The need to answer these public policy questions has been further underscored by the move to managed care. Welfare reform simply intensifies the need for answers.

Managed care and welfare reform present counties with a challenge and an opportunity. Both these reform efforts have clearly defined the target population that the public-sector AOD system is called upon to serve. By focusing on Medicaid and welfare recipients, the public sector can begin to define the number and types of persons who may utilize services. Existing public-sector management information systems can make available such data as the number, age, gender, ethnicity, aid code, and location of eligible beneficiaries.

County public service systems can also evaluate what types of programs and what levels of service capacity may need to exist in order to provide care for specific target populations. Finally, welfare reform offers the opportunity for the public sector to articulate a clear, concise, and pragmatic mission that includes specific outcome objectives.

Broadening AOD Outcome Measures

Establishing a defined set of public objectives and a specific target population both allows and compels county public-sector AOD authorities to develop broader performance outcome measures that evaluate more than abstinence and completed treatment episodes. Performance outcomes need to become multidimensional to address key elements of an individual's life beyond that person's chemical dependency issues.

The provision of public AOD services positively influences the utilization and cost of a number of other publicly funded health, social service, and criminal justice programs. It is, therefore, important that the county AOD treatment system develop a shared responsibility with other agencies. County and local AOD authorities need

to develop horizontally integrated service systems in cooperation with other public agencies. These integrated service systems should incorporate a shared set of performance outcome measures.

Because of managed care and welfare reform, public-sector AOD providers and their integrated service systems need to develop performance outcomes for broader problem measures. These measures should incorporate such indicators as:

- Employability/school participation
- Incarceration rates
- Use of out-of-home placements for youth
- Utilization of emergency rooms and hospitalization
- The number of drug-affected infants
- Compliance with child welfare agreements

Welfare reform's emphasis on employment creates a new opportunity. County AOD systems may now work collaboratively with local social service departments to provide recovery services to clients who need these treatment services to become employable.

Outcome measures for employability may include such indices as obtaining and retaining a job, progress in school or vocational training, and, in the case of youth, school attendance and academic achievement. These are all objectives that need to be achieved if States and counties are to comply with the work requirements of the Federal welfare reform legislation. To reduce the utilization of costly emergency and hospital services, managed care initiatives in either physical or behavioral health care require that AOD services meet certain criteria, such as that they be provided on a timely basis, at the right intensity, at the correct level of care, and for an appropriate duration of time.

The New Systems-of-Care Approach

To achieve these outcomes and to implement new or expanded public policy objectives effectively, public-sector AOD providers need to provide a comprehensive spectrum of services for specific target populations. This means that counties need to develop a systems-of-care approach. To provide the full spectrum of both treatment and social support services needed by individuals with severe addictive disor-

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Performance Measures For County Behavioral Health Systems

County substance abuse agencies, like State agencies, face pressures to increase their performance evaluation. The County Behavioral Health Performance Measures Project of the National Association of County Behavioral Health Directors (NACBHD) responds to this need. The NACBHD, in conjunction with the Evaluation Center of the Human Services Research Institute (HSRI), has developed a comprehensive set of performance measures intended to monitor and improve quality for mental health and substance abuse systems.

This set of indicators is particularly relevant to service delivery at the county level. Performance measures are the result of a roundtable meeting sponsored by the NACBHD. Behavioral health directors from 21 counties in 19 States attended this meeting, representing all but one of the 20 States that have county-administered behavioral health systems. Experts from a number of Federal agencies, including CSAT, participated in this roundtable. Each county participant selected one domain to work on. For each domain, the groups identified three to five specific performance indicators, along with associated measures. The group chose the following performance domains:

- Access
- Satisfaction of service recipients
- Consumer outcomes
- Intersystem outcomes
- Utilization

For information about *County Behavioral Health Performance Measures: Draft Version*, July 13, 1996, contact Lawrence Woocher at HSRI, phone 617-876-0426. In addition to the set of performance indicators, this document contains summaries of indicators developed by 11 national and local organizations, as well as copies of 9 standard assessment instruments.

Adapting to a Managed Care Environment

— Cynthia Turnure, Ph.D., Director, Chemical Dependency Program Division, Minnesota Department of Human Services

As States move from a fee-for-service or grant-in-aid system to a managed care system for publicly funded substance abuse services, the State AOD agency will face many challenges. It may no longer be the lead agency in terms of contracting, reporting, and monitoring. To ensure adequate monitoring of substance abuse services in a managed care environment, many State AOD agencies now need to develop new types of relationships. In Minnesota, we have 10 years of experience with a managed care environment. This article highlights what we have learned and what challenges we face. We recommend the following steps.

Determine the essential indicators of access, quality, and effectiveness, and work to build these into the new system. Each State may define these key indicators somewhat differently, but the State AOD agency has a responsibility to articulate them clearly for their clients. States may want to answer these questions:

- How many clients receive chemical dependency (CD) services? In what settings? What type of clients?
- How much service do these clients receive?
- How much do these services cost?
- Do clients improve their functioning after treatment?
- What are the cost-offsets in terms of reduced medical care utilization, criminality, and social service needs?
- Are the CD services delivered under managed care adequate, given the need?
- How does managed care compare to other systems of care (for example, fee-for-service)?

These are important questions, but it may not be possible to answer all of them. State AOD agencies need to decide which questions are essential for them, and then figure out how to get relevant information in this new environment.

Build on existing systems where possible. In States that have already developed sound reporting systems for CD services, try to convince those who are in charge of the larger health care data systems to use or adapt existing systems. In Minnesota, we are fortunate to have a well-established client tracking system, the Drug and Alcohol Normative Evaluation System (DAANES). All licensed providers must use the DAANES to report data. It may not be possible to convince those who are contracting with managed care firms to require such detailed client reporting on one "diagnosis," especially when such systems do not exist for other illnesses. In this case, build the detailed client reporting into your program licensing requirements and oblige managed care firms to use licensed programs. It is less important *who* collects and analyzes the data, than that *someone* does it.

Recognize that to those responsible for providing all health care, substance abuse is just a small part of the picture. If those in charge don't seem to pay much attention to your issues, it may not be that they don't care, but rather that they have so much *else* to deal with. Be persistent, proactive, and *helpful*. Offer to collect and analyze the CD data for them, take the lead in responding to Medicaid waiver issues related to CD or in training providers or producing reports. *Don't just complain — help solve their problems*.

Try various approaches. If one approach doesn't work, try another. Adapt your systems to meet the needs of this new environment, keeping your *overall* goals and indicators in mind.

In Minnesota, rather than requiring the managed care organizations themselves to report on our client data collection systems, we worked with them to devise a brief, half-page form on their assessment and placement activity. These data have enabled us to track placement patterns and to link the data to our DAANES for further analysis.

If some other State agency, such as the Health or Commerce Department, already collects some data on CD clients served by HMOs, *build on that. Don't duplicate it.* Similarly, if whatever will be collected on all managed care services (e.g., encounter data) will be useful for some purposes, find a way to access and use it to *complement* the other data needed to address your State's key questions.

Use the data. It is important to get the results of any data collection and monitoring effort to those who need them. This includes providers, legislative staff, managed care organizations, and your own agency. We have published the results of our data collection in a variety of ways, such as in our quarterly newsletter *Research News* that is distributed to over 900 individuals and organizations. A recent issue compared placement patterns, completion rates, and lengths of stay for clients placed by prepaid managed care plans vs. Minnesota's Consolidated Chemical Dependency Treatment Fund. These clients were matched on age, sex, race, and other factors. We have also produced one-page handouts on topics of high interest, such as the cost-offsets of CD treatment in Minnesota. These handouts have been widely quoted and used.

Work closely with the CD field and others who have a mutual interest in providing adequate treatment to CD clients, such as providers and consumers. There are times when our constituency can promote things (such

as uniform placement criteria or uniform reporting requirements) that government employees can't because of our position in the bureaucracy. Take advantage of these common interests and let our constituents do the lobbying, if that's necessary.

Get involved. My staff and I have served on every health care reform committee in our department. Because of the uncertainty of health care reform at the Federal level, many of these efforts have not gone anywhere. Nevertheless, you need to be seen as a player in the larger issues involved, not just as an advocate for CD clients. Contribute what you can of your time and expertise to broader issues, such as health care cost containment, Medicaid, block grants, and performance measurement for managed care in general. Make yourself useful in helping to solve the larger issues facing your agency and State.

Future Challenges

What challenges still lie ahead? We have made progress in some areas, but we are still struggling with a number of issues.

Influencing the overall evaluation plan for managed care in the State. While we have tried to build in whatever CD measures we can, the overall design for evaluating managed care in Minnesota is still not well developed. We have a State Data Institute that produces report cards on all HMOs in the State, based mainly on consumer satisfaction surveys. Our Medicaid agency is pursuing encounter data. However, no one seems to have articulated the *questions* that need to be answered, which should be the first step. We will continue to try to be involved in these efforts, but it is often frustrating.

Not losing what we have. In Minnesota, the CD field is ahead of many others in terms of collecting data, measuring client outcomes, and having uniform assessment and placement criteria. There is a danger that the State AOD agency's concerns could be swallowed up by health care reform and managed care, either in terms of reorganization or in going to the lowest common denominator in quality assurance and reporting. Without strong support from the CD field and legislators, we may go backward rather than forward. We will have to fight for the appropriate balance between accountability and freedom to "manage" in a managed care environment.

Determining where substance abuse services fit in a new and constantly changing environment. Health care reform and other changes at the Federal level (e.g., rescinding Supplemental Security Income benefits for those disabled by AOD abuse) have forced us to rethink where substance abuse services belong in the new scheme of things.

Are substance abuse services really "health care"? If so, do these services belong under "acute" or "long-term care" benefits? What about the *nonmedical* aspects of treatment (such as housing, child care, and vocational counseling) that are necessary for some clients' successful treatment? Should these be part of a "social services" package, perhaps funded through block grants to counties? How can "medical" and "social" services be coordinated so clients do not fall through the cracks? Where does prevention fit, and how will community-based prevention programs be funded in the future?

All of us will need to reconceptualize how adequate CD services can be provided in this new environment, at a time when much is still unknown. We do not, for example, know the future of Federal block grants or the changes that may occur in Medicaid. At the State and county levels, we may need to utilize whatever funding we do control in very different ways, such as separating funds for treatment services from funds for housing. How we use the Federal alcohol and drug abuse block grant may change radically, at least in Minnesota. And we will have to figure out how to provide essential services, such as case management, to those terminated from the Social Security Income and Social Security Disability Insurance programs. The impact of welfare reform on AOD clients must also be assessed (e.g., the denial of benefits to convicted drug felons).

Determining how to assure accountability for public funds and public clients in a privatized, deregulated system. As systems of care become more competitive and the distinction between public and private systems of care blurs, it will be increasingly difficult to ensure accountability. Private HMOs are not anxious to share their data or placement criteria with others in the marketplace. Many States are becoming less regulatory, based on the philosophy that the private sector has the right to manage care and should be accountable only for the outcomes.

This leaves a potential gap in accountability. State agencies will have to devise more sophisticated ways to ensure accountability. One way would be to use needs assessment data on whole populations. These data could then be compared with services actually delivered by various managed care firms to various population groups. In Minnesota, our legislature has asked the State AOD agency to develop utilization standards and financial or other incentives for all health plan companies in the State. These will provide a way to measure the adequacy of CD services in a managed care environment. Along with encounter data, we will be using the results of our CSAT-funded adult household survey, plus student surveys, to address this issue.

Clearly, many of the challenges faced by AOD agencies in the coming years will be political, not just technical. They will test our human relations, communications, and collaboration skills as much as our technological or substantive knowledge. While we can learn from what others have done, each State's approach will be different

based on its history, politics, and philosophy. Hopefully, our agencies can be a significant factor in building new systems that will meet the needs of substance-abusing clients.

Key Questions: The Effects of Managed Care On Mental Health and Substance Abuse Services

1. Does the plan for providing mental health and substance abuse services through managed care create additional barriers to accessing needed treatment, especially for hard-to-reach populations (e.g., through delays in obtaining referrals, having to go to multiple clinics, or choosing a health plan)?
2. Is the treatment provided (or authorized) under managed care of sufficient duration, type, and quality to obtain acceptable client outcomes, given the types of clients being served?
3. Are the "gatekeepers" under managed care adequately trained to detect, assess, and refer these disorders?
4. Do the definitions of "medical necessity" used by managed care firms deny care to certain categories of clients (e.g., those who are court-ordered)?
5. Does the lack of independent assessors and/or uniform assessment and placement criteria result in referrals that are subjective, inconsistent, or motivated by financial vs. clinical considerations?
6. Under managed care, are adequate services being provided to special populations (such as minorities, dual or multiply disabled clients, the homeless, pregnant women, or injecting drug users)?
7. Is there evidence that some models of managed care work better than others (e.g., "carve outs," HMOs, preferred provider organizations [PPOs], Point-of-Service)?
8. Are the health, mental health, and substance abuse services provided under managed care adequately coordinated with the social and other "supplemental" or "wraparound" services needed by public clients?
9. Is there adequate monitoring and evaluation of the mental health and substance abuse services provided under managed care? Are data on assessment criteria, placement patterns, length of stay, program completion, and client outcomes regularly reported to a neutral oversight agency? Are there sanctions (either positive or negative) for poor/excellent performance?
10. Do managed care organizations provide adequate protection of clients' rights?

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ders, it is essential that AOD services be coordinated with other health and social service agencies.

Systems of care require an interdependence among providers, so they accomplish shared treatment goals and outcome measures. This systems-of-care approach is significantly different from the provider networks that have been established by most public-sector AOD authorities. Existing provider networks typically consist of a constellation of providers that operate independently. Improvements in specific areas of client functioning require that treatment and service approaches be coordinated among a variety of different programs and community agencies. These programs include supported employment and affordable, clean, and sober housing.

Linking Outcomes to Client Functioning

The future of AOD treatment outcomes is linked to improvements in clients' functioning. The success of public-sector AOD clients is measured by how well these clients are able to perform once they are in recovery. Recovery in and of itself is only one ingredient in determining effectiveness. The new test of effectiveness is whether clients are able to capitalize on their recovery to achieve other life goals. As part of any comprehensive AOD system of care, public-sector providers also have to incorporate the teaching of appropriate adaptive skills.

Public-sector AOD delivery systems are evolving from their historic role as a safety net into an emerging managed care environment. This shift is creating an imperative to develop a broad range of valid and reliable outcome measures. Such outcome measures should ensure that quality services are accessible, efficiently delivered, and cost-effective. These services also need to meet specific public policy objectives.

Managed Care and Dual Diagnosis
Who, What, Where, Why, and How Much Care?

— Richard Ries, M.D., Director of Outpatient Psychiatry and Dual Disorder Programs, Harborview Medical Center, University of Washington, Seattle, Washington. Dr. Ries was consensus panel chair for the CSAT Treatment Improvement Protocol (TIP 9), Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.

How will managed care approach the treatment and management of persons with co-morbid mental illness and alcohol and other drug (AOD) disorders? What are the key issues that clinical professionals or consumers would want addressed? Jeffrey N. Kushner[1] has raised a series of critical questions for States to consider in setting up managed care contracts for AOD treatment in the following major areas: access to treatment, comprehensiveness of treatment, cost effectiveness, quality of care, client outcomes, and the managing of managed care.

Access to Services

Who will be screened and who will qualify for services? A high prevalence of dual disorders is found in either addiction or mental health populations. This fact suggests that all persons who present at either doorstep should receive an adequate screening for the other problem. This immediately raises two important issues discussed later in this article — the issue of the database to be used and the training of the screener.

Currently, most integrated dual disorder treatment programs focus on the most severely mentally ill clients; that is, persons with severe and persistent mental illness and co-occurring drug/alcohol disorder. However, what type of client is appropriate for treatment in a "dual disorder program"? Should a person in recovery from severe alcoholism who then develops an episode of major depression be treated in this type of program? Or can this person be treated in a primary addiction-oriented program that also provides episodic psychiatric consultation? On the other hand, does someone with severe, chronic, disabling mental illness, who has infrequent alcohol abuse (not dependence), qualify as dually disordered? Does this person require dual disorder treatment in the same way as a person with severe mental illness who has daily, dependent alcohol and cocaine intoxication?

Even this brief discussion makes clear that access to "dual disorder treatment" involves various levels of severity on at least two axes — relative severity of the psychiatric disorder and relative severity of the substance use condition. Managed care review and treatment planning will need to focus on matching different types of treatment intensity to each of the types of problem. No single entity "dual diagnosis" treatment will be appropriate or meet the needs of all the different types and combinations of dual disorders.

What instruments and criteria will be used? The mental health and addictions fields each has a variety of screening instruments, which creates a problem in the case of dual disorders. If there are 10 commonly used instruments for chemical dependency assessment, and 10 for psychiatric condition, there would be 100 combinations possible. Which one of these combinations should be used for dual diagnosis assessments?

It is likely that many dually disordered individuals will be referred to dual disorder treatment from primary addictions or primary mental health treatment. This means that the managed care organization must communicate its assessment criteria for one or the other disorders, and must also agree internally (between addictions and mental health divisions) as to what standardized instruments will be used. Currently, it is rare to find addiction and mental health programs that share a mutual database at any level — from private carriers to city, county, State, or even Federal-level systems. Without a common database accepted by both mental health and addictions, managing care by either provider or insurer will be very difficult.

The national institutes on drug abuse, alcohol abuse and alcoholism, and mental health, as well as the programs operated by the Substance Abuse and Mental Health Services Administration, need to provide a model of such a cooperative database. Such a database should have both research and clinical management versions.

Who will certify treatment? Training personnel to act as managed care reviewers has been a common problem for both the AOD and mental health fields. Dual disorder review will require co-trained personnel who have either certification or some sort of documented training in both areas. Since even finding co-trained staff who can operate dual disorder treatment programs is a problem, where will these extra co-trained staff come from? The field of psychiatry has been increasing its requirements regarding addiction and now has available a national board subcertification in addiction psychiatry. Each field must persistently move toward better training, at all levels, in the other field.

Comprehensiveness

What are comprehensive dual disorder treatment services? A seamless set of services is needed, ranging from prevention to highly secure locked units capable of dealing with clients who have violent psychoses accompanied by alcohol withdrawal. But how comprehensive can such a

system afford to be? For example, will intensive case management, sober residential placement, and integrated vocational rehabilitation be considered as core services for persistently mentally ill, dually disordered persons? Currently, many such individuals in HMO-type systems rapidly use up their limited AOD and mental health benefits, then devolve to the public system. How comprehensive will private and HMO-type services be, and who will bear the costs if such services are inadequate for complex conditions?

Cost Effectiveness

A high cost is involved in using a non-integrated approach to treat individuals with dual disorders. Most research indicates that dually diagnosed persons are over-represented among the homeless, are heavy users of acute inpatient services, and are over-represented in the criminal justice system. This high cost creates a major motivating factor for developing improved dual disorder treatment.

One method for treating severely mentally ill clients is through programs for assertive community treatment (PACTs), a model that involves intensive case management and outreach. The PACT model usually results in about an 80 percent decrease in acute hospitalizations and incarcerations over traditional treatment. However, the costs of assertive community treatment programs nearly counterbalance the cost savings, since they include 24-hour outpatient coverage and intensive case management. Although the cost saving may be marginal, clients/patients are much more satisfied with assertive community treatment than with acute hospitalization or incarceration, because their quality of life is much better with community treatment. How do we analyze this cost?

Continuous cost offset data are not available for specific dually diagnosed populations over a significant number of years, nor is such data likely to be available soon. Cost offsets for dually diagnosed populations must also calculate legal and jail expenses, crime, individual and family suffering, quality of life, and medical utilization. Unfortunately, these cost effects may not be included. Who makes these choices?

Capitation

If the financing system uses capitation, will dually diagnosed persons be risk-adjusted for payment at a higher level, and if so, how much more? Should increased risk adjustment hold for all the dually diagnosed, however defined, or only for certain of the more severe subgroups? Research data indicates that dually diagnosed persons have worse outcomes and poorer participation than those without a dual diagnosis in either primary mental health or addictions treatment. This finding would tend to support providing an increased capitated rate for these clients. An increased capitated rate could be used to support expensive integrated services, increased salaries for dually trained staff, and increased intensity of treatment. Despite the common sense of this approach, I have yet to find a public or private financing system in which this has occurred.

Quality of Care

No confirmed treatment guidelines exist for dual disorder clients, although a number of texts and manuals have been developed for the treatment of various dual disorder subpopulations. The American Society of Addiction Medicine (ASAM) is currently reviewing its patient placement criteria for addiction for the dual disorder population. To date, this ASAM initiative has just begun to match subtypes of dually disordered persons with potential treatment guidelines. The 1997 summary from the Center for Mental Health Services provides an extensive qualitative literature review on dual disorders.[2]

Quality-of-care markers for the dually diagnosed population could certainly be taken from separate mental health and addiction treatment guidelines. However, can these be imported fully for integrated treatment? Say, for example, that a quality-of-care guideline for intensive outpatient chemical dependency treatment requires a minimum of 12 hourly groups per week to occur around topics x, y, and z. For intensive outpatient mental health treatment, the guideline requires roughly the same number of hours per week to include issues a, b, and c. Does this mean that, for intensive outpatient dual disorder treatment, 24 hours of group per week including topics a, b, c and x, y, and z need to occur?

A more realistic approach might be the following:

- 12 or 15 hours per week would qualify for intensive outpatient dual disorder services.
- Topics a, b, c and x, y, z would be covered in an integrated fashion over a time period lasting approximately twice as long as either intensive mental health or chemical dependency outpatient treatment alone would normally last.

While this is the way many clinicians have approached these problems, who makes such quality-of-care decisions for the managed care company?

Client Outcomes

For those in straight addiction treatment, multiple relapse episodes may lead to their treatment coverage being limited or canceled. For more severe dually diagnosed persons, multiple relapse episodes during the engagement phase of treatment are probably the norm.

When treating acute or episodic conditions, managed care often identifies decreased utilization of services as being a positive outcome. However, this may not be the goal for many dually disordered persons. In fact, for

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Setting Realistic Contract Rates

— Roberta Gardine, Executive Director, Hawthorn Children's Psychiatric Hospital, St. Louis, Missouri, and Stephenie W. Colston, Project Director, State Technical Reviews Project, Johnson, Bassin & Shaw, Inc.

Clearly, the AOD field is facing a significant challenge with managed care. As is typically the case, the experience of providers will guide the field in developing appropriate responses to these issues. If providers are to survive under managed care, they must be able to define and report costs in a way that makes them competitive in the managed care marketplace.

Grant and fee-for-service providers may feel overwhelmed and out of their league when forced to think about, discuss, or operate using managed care financing principles. But providers cannot afford to wait until a cookbook on managed care pricing and service delivery is developed to provide a simplified, step-by-step guide to this process. Providers need to begin the transition by learning about and understanding basic principles of cost accounting for managed care. They need to start now to put systems in place for gathering needed information within their provider agencies.

The Problem of Measuring Service Costs

As managed care initiatives are implemented throughout the country, the AOD field is being forced to face a long-standing problem: the lack of standard ways to measure units of service and their corresponding cost components. This lack of a systematic approach has meant that studies of AOD costs have traditionally calculated the cost per treatment slot, based on dividing the number of enrolled clients into the dollar amount spent on services. With this approach, there is no relationship between discrete treatment units and the resources expended by the provider. To survive under managed care plans, the emphasis has been simultaneously on how to control access, utilization, and the cost of providing services for a variety of payers.

In this managed care environment, it is no longer enough for AOD providers simply to calculate a reimbursement rate based on available staff time. Rates must now take into consideration the actual number of units of service provided.

Providers face this issue of unit costs when they attempt to negotiate contracts with managed care entities. In a number of States, these entities are suddenly in charge of disbursing public AOD funds that had formerly been disbursed by State agencies on either a grant or fee-for-service basis. Providers are learning that managed care entities typically do not negotiate a reimbursement rate. They simply *tell* providers what the rate will be. Providers must know what the impact of such a rate will be on their agency's overall financing before they decide to sign managed care contracts.

Providers need to consider and take a series of positive, practical steps before they accept contract rates with managed care entities. These steps involve two key elements.

Providers need to understand thoroughly the differences between grant and fee-for-service markets and the emerging managed care markets. And providers need to be aware of the importance of documenting how treatment staff spend their time. They need to know how to use units of staff time for calculating the cost of providing treatment services.

Two Systems: Two Different Dynamics

The first step in setting a realistic contract rate is to obtain a basic understanding of how operating in a managed care market differs from a grant or fee-for-service market. Most States and providers have enjoyed and managed successfully for years in a market that uses grants or fees-for-service to pay for services. Providers have learned how to make adjustments to maintain the viability and stability of their agencies. Available revenue, more than any other factor, has determined provider costs. Providers frequently respond to revenue cuts by reducing the amount of service, the quality of care, or both, and react to revenue increases with the opposite response — by expanding services and/or improving the quality of care.

In both the grant and fee-for-service markets, payment mechanisms have not been tied to the cost of providing the service. Therefore, providers have had no financial incentives to monitor and contain costs.

In the managed-care market arena, the principles of setting a rate, the incentives, and the resolutions to problems are vastly different. In fact, these principles are diametrically opposite those in the grant and fee-for-service markets. In a grant market, the provider receives the same amount of funding per month regardless of the cost or number of units of service provided. In a fee-for-service market, the provider tries to establish the highest price possible for services and to maximize the number of units of service provided. In grant and fee-for-service systems, there is no incentive to provide either fewer or less costly services. The provider may fix any revenue shortfalls by adjusting the service mix or by increasing service units. To make these changes, providers do not need any individualized client data.

In a managed care environment, the payer has a financial incentive to contain costs. This naturally drives the reimbursement rate down and leaves less flexibility to negotiate a higher contract rate. Additional cost containment or reductions will be achieved by

limiting care to service levels that are medically necessary and appropriate and by decreasing the length of authorized service. These critical decision points are largely outside the provider agency's control.

There are also financial disincentives to providing such traditional services as residential treatment, which is a core service to many providers. For providers, the loss of these core services has a multiplying negative impact on revenue, because core services have historically been a vehicle for covering many indirect costs. As a result of this shift in reimbursement and funding, the majority of providers find themselves ill equipped to compete in a managed care environment.

Determining the Provider's Cost of Service

If they are to survive financially, it is essential that providers know their costs of service *before* entering into a managed care contract. To be competitive in this environment, the provider must be able to establish a contract rate per service which is at a margin in excess of provider costs. Providers must know their break-even point (the point at which they begin to *lose* money). If a provider is unable to answer the basic questions about what it costs to provide a service unit, and cannot establish that margin above cost, the provider is not ready for managed care contracting.

If unit costs are not known, the provider may blindly enter into contracts and then subsidize any losses through other agency payer sources. The provider is now robbing Peter to pay Paul. There is a basic flaw in this creative funding strategy. The lack of costing information that led to robbing Peter in the first place contributes to indecision regarding where to stop to avoid losing substantial agency revenues.

Too often, the provider's first response to this problem is to produce more units of service — the strategy that worked under a fee-for-service system. However, if the provider has set a rate at a level that is below cost, increasing the number of units of service will only increase loss. The provider cannot spend itself rich. Intensifying this problem is the fact that most not-for-profit providers have a shortage of available revenue and cash flow. By the time the pricing error is realized, the provider is already in financial trouble.

Costs for an Episode of Care

Providers have traditionally established rates based on overall program expenses. Managed care reimbursement is based on the cost of treating an individual episode of care. To establish a realistic rate, the provider must define an episode of care. The field has been grappling with what constitutes an episode of care since the implementation of managed care. For purposes of this article, we have adopted the definition of McGuirk, *et al*.: "An episode of care is a construct that groups all the treatment provided for a specific condition over a continuous, defined period of time; [this concept is] often used to analyze service cost, quality, and utilization patterns."[1]

To obtain episode-of-care information, the provider must begin to gather data on patient profiles. Through clinical data systems, the provider must be able to document episodes of care per client. This data must then be integrated with financial systems to provide data on treatment and length of stay according to diagnostic category and by client. By analyzing this data, the provider can learn the historical patient profile trends for the agency.

Based on these past utilization patterns, the provider already knows the revenue and financial stability of the agency. It is therefore possible to assess quickly the point at which a change in utilization will negatively impact the agency. Historical data will only produce trends for the agency, not tell the optimal service level needed to produce the desired outcome for each episode of care. In analyzing this data, the provider needs to challenge and question the agency's service delivery patterns. This data provides an invaluable base for making decisions about service utilization. What is needed is to try to move service utilization to the minimal pattern of treatment (in terms of units of care) that can achieve the desired outcome for each patient.

The provider should ask such questions as, "Does an episode of care apply to the acute phase only? Does it include case management or other services to maintain clean and sober status or prevent future problems? If so, how much care is medically necessary to obtain the desired outcomes?" These become pivotal questions in determining how many service units the payer may authorize as "medically necessary."

Providers need to be critical in challenging their agency benchmarks and profiles. Most providers will find it somewhat difficult to be objective as they enter this phase of analysis. Patient profile standards for behavioral health care are almost nonexistent. We need to recognize that these decisions must often be made without good supporting documentation.

Despite the lack of concrete data, providers must start collecting and using whatever patient profile information is available as a basis for pricing a service or negotiating a contract rate. These factors will help the provider establish how many units of service the outside payer sources can realistically be expected to authorize. They can also be used to determine the potential impact of these payer decisions on the provider.

How Staff Time Is Spent

Many public and private nonprofit providers have done less than an adequate job of logging all staff time.

Billable units are not usually a problem. Generally, staffs document and log their billable units as requested. Staff compliance with logging nonbillable time has been more difficult to maintain. Supervisory or administrative staff often do not monitor nonbillable time closely, if at all. Providers need to obtain this information so they can determine whether the units of service anticipated to be authorized for an episode of care will actually cover the direct and indirect costs of providing the service. Without this information, the provider cannot determine whether staff can and will generate sufficient reimbursements to cover the real costs of service.

CSAT has funded considerable research geared toward understanding the cost of providing AOD treatment services. This research depends on the appropriate documentation of treatment staff time. CSAT recognizes that such staff time is important for documenting the cost of providing treatment services. One pilot study of patient service costs in selected AOD treatment sites was conducted in 1994 by Johnson, Bassin & Shaw, Inc. (JBS) and its subcontractor, Research Triangle Institute (RTI), under the auspices of the State Technical Reviews Project. This was essentially a cost-finding study of 13 publicly funded treatment programs throughout the United States. The study sought to determine how staff spent time on specific services. This was used as the basis for allocating costs and for providing real-time, full economic costs of services rather than historical costs.

The researchers developed a diary methodology to ascertain how treatment staff spent their time. Each treatment staff person was asked to maintain a time activity diary for 1 week. This provided a 1-week snapshot of the actual time each staff person spent in delivering both treatment and non-treatment services to clients. In this study, the diary methodology thus became an important measure of staff productivity. The compiled diaries made it possible to estimate the quantity of services that each client received during a typical stay. The diaries showed that approximately 100 specific types of services were being provided.

CSAT Study to Aid Providers

CSAT asked JBS and RTI to embark on a second cost study to develop a market-based financial planning model. The goal of this effort is to create a tool for States and providers to project costs and risks under a variety of scenarios that can be tailored to specific market conditions within the changing financial environments. The model is designed to take providers and States from a static analysis of cost and paper-based risk projections to a computer-based simulation model. A software diskette will be produced for providers to use in projecting their costs and revenue, along with a user guide summarizing business planning and cost analysis principles.

Whatever level of fiscal and clinical sophistication you have as a provider, that's where you are and where you must begin to develop cost information. Build on each component as information becomes known. Providers will be surprised at how far they can move by just getting started. Provider cost information is essential for purposes of internal management, MCO contracting, and provider profiling. As more States move towards outcomes-based funding, provider performance will be profiled on the basis of both treatment and cost effectiveness. Providers capable of analyzing their costs will be well prepared to meet this challenge.

[1] McGuirk, F.D.; Keller, A.B.; and Croze, C. *Blueprints for Managed Care: Mental Healthcare Concepts and Structure.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, May 1995, p. 64.

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more severely ill individuals, low participation in outpatient treatment often leads to their use of expensive acute emergency room, inpatient, and jail services. A drop-off in participation may lead to the client's stopping of medications or loss of sobriety. For many dually disordered persons, whose conditions will be chronic and relapsing, the first positive outcome might be *higher utilization* of outpatient treatment. After participation, the problem of finding a common measure for symptoms and functions emerges. (See above, *What instruments and criteria will be used*?)

Dually Disordered Clients in Managed Care Environments

Who will actively manage the care of dual disorder clients? If an entity is developed that will manage dual disorder treatment, where will this fit? Will the individual divisions of addiction treatment and mental health treatment oversee such an entity? If so, it is likely that this entity will be so burdened with double and often conflicting bureaucratic requirements that it will not function. If neither mental health nor addictions supervises this new dual disorder entity, who will?

Clearly, the current division of addictions and mental health is inefficient and problematic in terms of information, funding, legal issues, training, and clinical structures. Would it be too radical to propose that the primary entity must be dually competent and that current divisions of mental health and addiction become subdivisions?

[1] Kushner, J. N. Managing State Managed Care Contracts, *TIE Communiqué,* Spring 1995, pp. 20-21. See also Mr. Kushner's articles in this issue.

[2] Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project, Co-occurring Mental and Substance Disorders (Dual Diagnosis) Panel. Kenneth Minkorr, M.D., Panel Chair. July 1997.

Special Population Challenge: Preserving Positive Outcomes for Women Clients

— Mary H. Bair, Division Director, Gaudenzia, Inc. Women and Children's Programs, Harrisburg, Pennsylvania. Gaudenzia, a leader in the field of women and children's services, is the parent organization for four Pennsylvania programs offering treatment, intervention, prevention, and education services for pregnant and parenting women and their children: Vantage House in Lancaster, New Image in Philadelphia, Kindred House in West Chester, and Gaudenzia Fountain Springs in rural Schuylkill County.

For the past 25 years, we have been struggling to provide and fund quality addictions treatment and programming for pregnant and parenting women and their children. How can we preserve the broad-based, continuing care we have fought so hard to provide for this special population?

The Struggle for Long-term AOD Care

Providers of long-term, residential therapeutic community (TC)-based treatment for pregnant and parenting women with children have been involved in several dramatic turning points in the AOD field. Pennsylvania's experience illustrates how far we have come in our efforts to assist poor and uninsured women with addiction problems — and how much we could lose as funding streams change. Our beginnings in the late 1970s were meager. At that time, the State provided virtually no specialized treatment services for poor, substance-abusing women who were pregnant or parenting.

Pregnant and parenting women with children were being referred for admission to treatment only to become lost in a maze of service delivery systems that could not meet their particular needs. Limited services were available to these women in facilities that were geared to men. Sometimes these services were counterproductive, with drop-out rates for women that far exceeded those for men.

Obstacles to treatment

Many mothers refused to enter treatment without their children. Most feared placing their children in foster care or with friends or family members who had an active addiction. Furthermore, placing their children with various childcare agencies was not an option for these mothers. Many had themselves grown up in those very systems, where they had often experienced mental, physical, or sexual abuse.

Providers refused to accept pregnant and parenting women with children for fear of insurance liabilities and possible lawsuits, or because the providers lacked on-site medical services and were not equipped to provide intervention, education, and alternative activities for the children. The issue of funding compounded these obstacles. Who would pay to provide treatment services not only for these mothers, but also for their children?

The struggle for program funds

Gaudenzia, Inc. joined forces in 1978 with the Lancaster County Mental Health/Mental Retardation Drug and Alcohol Program and the Single County Authority Planning Council to design a program specifically for pregnant and parenting women who were abusing or addicted to alcohol and drugs. This collaboration resulted in Gaudenzia/Vantage House, which pioneered the first long-term, residential therapeutic community in the United States targeted for this special population.

Funding services for this population continued to be a challenge over the next 10 years. The struggle for funds eased in 1992, when the Federal government mandated that States set aside a portion of their substance abuse block grants for specialized women's services. The Pennsylvania Department of Health's Office of Drug and Alcohol Programs (ODAP) established a State and county 90/10 funding pool for long-term residential treatment services for pregnant and parenting women and their children, which was eliminated in 1997. Those funds have been distributed to counties to address women's and children's services to include all levels of care. The impact of this decision on women and children in need of residential treatment remains to be seen.

Pennsylvania has gained national recognition for developing a statewide network, now totaling 52 programs, to serve the special needs of pregnant and parenting women and their children. Currently, Pennsylvania has 17 licensed long-term residential treatment programs for this population and provides 35 other licensed programs that specialize in treating pregnant and parenting women and their children. In addition, there are four perinatal and two correctional programs.

Issues with Managed Behavioral Health Care

Managed behavioral health care has jeopardized the ability of many specialized programs to serve pregnant and parenting women with children. Behavioral health care companies are simply not prepared to understand or treat this population. Our concern is that many of these companies will opt for income over outcomes. We cannot afford to let this happen.

A number of factors impede the ability of behavioral health care companies to serve low-income pregnant and parenting women and their children:

- Most managed behavioral health care companies have a limited view

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Measuring MCO Performance

— Jeffrey N. Kushner, former Director, Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources. Mr. Kushner is currently the Drug Court Administrator for the Missouri Circuit Court in the 22nd Judicial Circuit, St. Louis, Missouri.

Forty-five States have submitted waivers to the Health Care Financing Administration to provide health care to poor people in a managed care environment.

As States move to managed care modes for their public systems of medical, surgical, chemical dependency (CD), and mental health benefits, State bureaucrats, consumer advocates, and provider constituent groups need to be acutely aware of the decisions being made by managed care organizations (MCOs). This requires that State, and sometimes county, agencies gather accurate and audited information concerning MCOs' clinical and service performance, and inform constituent groups of the results.

An effective CD benefit can be one of the most cost-effective actions for publicly funded human service agencies. We must make sure that MCO decisions are made on the basis of benefit value and cost avoidance to taxpayers and consumers, not on spending reductions.

Therefore, we must measure indicators of treatment quality and effectiveness. To ensure that public purchasers maximize their CD and mental health funds, we must build quantifiable performance indicators based on what makes a difference for successful treatment outcomes. A wide range of performance indicators should be considered. They generally fall into six categories. (See box).

State purchasers, taxpayers, and consumer advocates need to be assured that these indicators are selected, benchmarked, and utilized. These indicators should be placed in contracts with MCOs and their subcontractors, along with financial penalties

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Performance Indicators

Patient/Customer Satisfaction

- Patient satisfaction survey data
- Family satisfaction survey data
- Appeals
- Disenrollments
- Purchaser satisfaction survey data

Administrative Proficiency

- Average time to appointment/clinical intervention for emergent, urgent, and/or routine cases
- Number and percent of individuals referred to treatment who are admitted
- Toll-free phone access for patients or providers to avoid busy signals, abandoned calls
- Claims payment accuracy and turnaround time (e.g., 90 percent in 45 days)
- Appeals resolution time

Clinical Quality

- Consistency in applying criteria for clinical case management
- Linkage and lag time between inpatient, residential, and outpatient services
- Staff with experience and credentials
- MCO gatekeepers with experience and knowledge of chemical dependency and mental health
- Consistency in applying a screen for chemical dependency problems at the annual physical, first prenatal visit, and other opportunities

Financial Performance and Incentives

- Penetration rate of chemical dependency services by enrollees
- Ratio of utilization of inpatient/residential services
- Nonresidential intensive alternatives and outpatient services
- Rate of payment utilized for service (e.g., rate of capitation payment used to purchase direct services)
- Distribution of direct service dollars by modality
- Cost per covered life

Productivity

- Abstinence levels at discharge/follow-up
- Participation in self-help during treatment/follow-up
- Employment or school improvement at discharge/follow-up
- Family reunification at discharge/follow-up (child welfare)
- Educational advancement at discharge/follow-up
- Reduction in criminal justice system involvement during treatment/follow-up

State Policy/Cost Shifting Considerations

- Reduction in rate of incarceration and institutionalization
- Reduction in the number or length of foster care placements
- Reduction in medical/surgical costs at follow-up
- Reduction in unemployment compensation

Oregon's Pre-Paid Health Plan
Chemical Dependency ScoreCard*

Measure 1: Efficient and Accountable Operations

Rationale: Health care providers often express concerns that: (1) authorizations for the delivery of health care services take too long (this is particularly important with chemically dependent patients because often there is a short window of opportunity to move them into treatment), and (2) reimbursement of services should be timely. This is very important within the chemical dependency treatment provider community, particularly if their primary source of revenue has been public funds. Such providers have very limited ability to accrue reserves that can cushion cash flow problems.

Indicator A—Simple and Timely Initial Service Authorization Procedures
The service provider is to receive a response to the initial authorization request within 2 working days from the time the health plan receives the authorization request. The Health Plan uses OADAP authorization and reauthorization (or equally simple) forms.

Indicator B—Simple and Timely Reimbursement Procedures
This measure reviews whether service providers receive payment or adjudication of 90 percent of their clean claims within 45 days.

Indicator C—Submits Timely and Accurate Encounter Data
Office of Medical Assistance Programs (OMAP) receives encounter data (Medicaid service delivery accounting system) on HCFA form 1500 within 180 days of delivered services.

Measure 2: Chemical Dependency Contract Compliance

Rationale: Twenty-one standards were inserted into the State's contracts with pre-paid health plans for the chemical dependency benefit. The purpose of this measure is to monitor compliance with at least some of those standards.

Indicator A—Levels of Care Criteria
This indicator reviews whether providers and plans are utilizing State-required criteria when making decisions concerning admission, continued stay, and discharge.

Indicator B—50 Percent Referral to Essential Community Providers
The State regards chemical dependency treatment providers that previously received public funds as Essential Community Providers (ECPs). The goal of the State is that each pre-paid health plan (PHP) refer to no fewer than 50 percent of OMAP members needing chemical dependency diagnostic assessment and/or treatment to ECPs.

Indicator C—Knowledgeable Gatekeeper
PHP staff or their delegated entities who evaluate access to and length of stay in chemical dependency treatment shall have training/background in chemical dependency services and knowledge of OADAP-approved placement, continued stay, and discharge criteria.

Measure 3: Prevention Program

Rationale: Managed Care Organizations have initiated an environment that emphasizes not only the treatment of acute medical problems but also prevention, early identification, and intervention. This concept is also applicable to prevention and intervention of chemical dependency within the enrolled population of the Oregon Health Plan. The measures included are structured to assess the degree of prevention and early intervention carried out by individual health plans.

Indicator A—Establish and Implement Risk-Focused Prevention Plan
Research has shown that a number of risk factors increase the chances of tobacco, alcohol, and other drug abuse problems, particularly among adolescents. Pre-paid health plans must develop a risk-reduction plan that also increases protective factors to reduce chemical dependency problems in their enrolled population.

Indicator B—Dependency Screening Instrument
PHP staff shall utilize approved screening instruments to determine whether a diagnostic assessment for chemical dependency problems is indicated for an OMAP member. Contracts require 50 percent screening of all patients in 1996, 75 percent in 1997, and 100 percent in 1998, in these circumstances:

(1) Initial contact or routine physical exam

(2) Initial prenatal contact

(3) Member evidences "trigger conditions" during a physical exam or emergency room contact (such as current intoxication, needle marks, dilated pupils, or suicide talk or attempt)

(4) Member evidences overutilization of medical, surgical, trauma, or emergency services

Measure 4: Access to Assessment and Treatment Services

Rationale: Public and private health care purchasers are concerned about (1) the number of people being served (is the number reasonable in relation to the total enrolled population?) and (2) special needs populations or geographic locations that may warrant attention due to low utilization of or access to chemical dependency services. This indicator acknowledges the State's accountability and responsibility to provide chemical dependency treatment to all Oregon Health Plan clients.

Indicator A—Member Admission Rate
This indicator examines the percentage of members in a plan that receive a chemical dependency service. The research would indicate that 2-to-4 percent of the Oregon Health Plan population should be admitted to chemical dependency treatment services per year.

Indicator B—Demographics of Chemical Dependency Treatment Admissions
No specific standards have been developed due to the wide variation in memberships and locations served among plans. Instead, member admission will identify and compare male vs. female, adults vs. adolescents, rural vs. urban, minority vs. non-minority. The results of the analysis will be made available to the plans and upon request to the interested public.

Measure 5: Treatment Effectiveness

Rationale: Health care purchasers, legislators, and other key stakeholders want to know that treatment meets quality standards and is effective. The following indicators are measures of treatment effectiveness.

Indicator A—Client Retention Rate
This indicator acknowledges the importance of maintaining the participation of clients once they have visited a treatment program and been admitted. Increased participation, particularly during the initial period of treatment, provides greater likelihood that a client will benefit from treatment.

Indicator B—Re-Admission Rate
This indicator is concerned with the durability of gains made while in treatment and measures only members who have completed treatment during a previous admission. Re-admission will be counted within one year from successful discharge. This measure does not include transfers to other program or levels of care.

Indicator C—Functionality Improvement, Including Employment, School Attendance, and Other Life Aspects
A critical element of sustained recovery is employment maintenance or enhancement. This indicator reviews employment status from admission to discharge for those with at least three face-to-face visits.

Indicator D—Reduced Utilization of Medical/Surgical Services
This indicator highlights the significant cost avoidance that derives from the reduced use of medical and surgical services by members who have completed at least two face-to-face treatment contacts for an alcohol and/or other drug problem. Two years of medical/surgical service utilization are compared: (1) the year preceding admission and (2) the year following discharge from treatment. The measure is the number of medical/surgical encounters.

Indicator E—Treatment Completion Rate
This indicator identifies members who completed at least two face-to-face contacts. It then calculates the percentage of those members that complete their treatment program (completion is defined as those achieving abstinence and at least 75 percent of their treatment plan objectives).

Measure 6: Client Satisfaction

This indicator will utilize a questionnaire yet to be selected to measure client satisfaction with services received from the health care provider.

*Note: For each indicator, the Oregon ScoreCard establishes specific, concrete measures for performance: below standard, achieved standard, and exceeded standard. As an example, the standards for Indicator A of Measure 1 are:

Below Standard: 10 percent or more not received within 2 working days

Achieved Standard: 90 percent received within 2 working days

Exceeded Standard: 90 percent or more received within 2 working days and used simplified forms

The complete Oregon ScoreCard may be obtained from the Office of Alcohol and Drug Abuse Programs, 500 Summer Street, NE, Salem, OR 97310. Phone: (503) 945-5763.

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and incentives. Providers and consumer advocates should insist on this type and level of accountability for public funds. The private sector, which has traditionally utilized only client and purchaser satisfaction, can also learn from this type of benchmarking and related accountability.

Oregon's ScoreCard Evaluation Tool

The Oregon Office of Alcohol and Drug Abuse Programs (OADAP) has reviewed a ScoreCard developed for the CD benefit in the Oregon Health Plan. Although score cards are being used extensively throughout the health care industry, this is the first to be developed for CD benefits with publicly funded AOD clients.

OADAP administers CD service contracts under the Oregon Health Plan. The OADAP plan calls for working in partnership with multiple stakeholder groups to provide quality, cost-effective, and timely care to chemical dependency clients. The new consolidated ScoreCard will be just one of the tools OADAP will use to evaluate performance of the prepaid health plans. The ScoreCard responds to a number of concerns, including:

- Implementing the State legislature's mandate that the CD benefit reduce the cost and use of medical/surgical services
- Assuring that AOD providers have a viable, fair, managed care delivery environment
- Assuring quality and timely care for clients
- Assuring that the prepaid health plans operate on a level playing field, in which all plans comply with required standards
- Monitoring whether performance is meeting the standards expected by State purchasers. OADAP will provide technical assistance when needed to improve performance.

Selection of Performance Indicators

The score card — a brief reporting tool — answers a need for objective information about health plan performance. The Health Plan Employer Data Information Set (HEDIS) has been adapted for the Medicaid population. Preliminary versions of this adaptation emphasized consumer convenience and satisfaction. OADAP chose not to duplicate this work. Instead, Oregon focused on developing an outcomes-based score card to supplement the HEDIS score card, using the following six measures of CD services:

- Efficient and Accountable Operations
- Chemical Dependency Contract Compliance
- Prevention and Early Intervention Program
- Access to Assessment and Treatment Services
- Treatment Effectiveness
- Consumer Satisfaction

These indicators build on the provider performance indicators that are measured in the databases of a number of Oregon's public health agencies. OADAP maintains a substantial database, with access to other State data.

For each indicator, there are specific, concrete parameters for what constitutes "below standard," "achieved standard," and "exceeded standard" performance. Among the objective performance indicators whose measurement will continue are abstinence, employment improvement, participation in self-help groups, and academic advancement.

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of addiction and little or no actual experience in treating pregnant or parenting women.

- Most companies have no track record of positive outcomes with low-income or Medicaid-eligible addicted women who have children.
- Many companies use commercial models of addiction treatment that have limited or no impact on these women.

Many managed behavioral health care companies lack the perspective of those who serve publicly funded AOD clients — that these are clients with multiple problems requiring a comprehensive continuum of care. Often these companies do not have a holistic or long-term view of addiction services.

Positive Steps by HMOs

The obstacles to adequate and comprehensive services under managed care can be overcome. In Pennsylvania, some of the health maintenance organizations (HMOs) that subcontract with managed behavioral health care entities have recognized their inexperience. These HMOs have set up special pools and financing that by-pass the behavioral health care companies.

These HMOs realize that adequate AOD treatment for a woman creates reduced costs in medical care for the woman's entire family. For this reason, HMOs are concerned with ensuring healthy births and immunizations for children, as well as preventing child abuse, domestic violence, and illness related to addictions — not only for the women but also for their families.

Another positive note is the increased awareness by Medicaid agencies of the need to provide comprehensive services as an adjunct to addictions treatment. State Medicaid Bureaus are now starting to recognize and actually provide these needed services in their managed care plans.

Defining Treatment Success: Issues for States

— Janet Zwick, Director, Division of Substance Abuse and Health Promotion, Iowa Department of Public Health

Treatment success can be defined in many different ways. When the measurement of success is related to managed care, it is essential to evaluate both cost savings and the effectiveness of treatment. The managed care organizations themselves often look primarily at client and consumer satisfaction as outcome indicators and to plan their quality management. Such indicators are not sufficient for a State substance abuse agency. A State agency must look far beyond client and consumer satisfaction, because the agency is responsible for assuring that the entire treatment system under managed care is functioning at an optimum level. This responsibility entails evaluation of the treatment system as well as changes in client functioning.

The Database and Baseline Data

The State needs to have available an adequate client and program database in order to evaluate the impact of managed care on the treatment system and, most importantly, on the changes in client functioning. Client information needs to be collected at admission, discharge, and follow-up. The information needed includes client demographics and information on the clients' functioning, along with the type of treatment provided. It is desirable that this client database be in existence for several years before managed care is implemented. Historical data provide a solid base of information on the level of treatment and client outcomes under existing publicly funded systems. This baseline can then be used to evaluate changes that may be caused by managed care. Success can be measured using at least five different components:

- Accessibility of treatment
- Types of treatment services provided
- Changes in client functioning
- Cost-offset data
- Consumer satisfaction (at both the client and treatment program levels)

Accessibility of Treatment

The accessibility of AOD treatment for all groups of clients across the State will be a central — and critical — question as AOD funding streams change and managed care or other new financial arrangements are implemented. It is important to monitor accessibility. How accessible is treatment for the State's individual ethnic, racial, and special populations? And does accessibility vary across different regions of the State? To determine accessibility of treatment, the following areas should be examined:

- **Waiting time for treatment**. The State must have the ability to compare waiting times among indigent clients, Medicaid clients, private-pay clients, and insured clients. In addition, waiting time should be computed for the pregnant client, for those referred by the criminal justice system, and according to gender and race.
- **Overall admission rates**. Overall admissions need to be evaluated to assure that they have not declined since managed care began. If admission rates have declined, then it is important to assess carefully the types of clients affected.
- **Level of treatment received**. The level of care that clients are receiving should be analyzed. If there has been a decline in admission rates for a particular level of care, all levels should be evaluated separately.
- **Rural vs. urban treatment services**. The level of treatment services provided in rural versus urban areas is another important access issue. If a decline in admission rates is seen, then the data should be further evaluated to see whether admission rates are related in any way to rural areas. States may want to conduct a needs assessment prevalence study to identify geographic areas that have a high prevalence of need. These results compared to admission rates allow the State to evaluate an appropriate distribution of services.
- **Denial of admission or denial to a particular level of care**. If denials concerning levels of care have occurred, then the State should evaluate those treatment settings and the risk levels of the client.

In a new managed care or other financial arrangement, it is also necessary to address the change in the provider system. What changes have happened in the provider system since managed care was implemented? Mergers, closings, and acquisitions can all impact the provider system and affect accessibility to treatment. Therefore, exploring these changes must be part of any evaluation effort.

Types of Services Provided

Managed care stresses the need to individualize treatment planning and to place the client in the least restrictive environment necessary for the symptoms. Research shows that the longer a client remains in AOD treatment, the more likely that treatment will be a success.[1] The dichotomy in these two statements raises obvious questions about the impact that managed care principles may have on AOD clients. States need to compare before and after managed care data to see whether the length of time in treatment has been significantly affected.

In addition, States should analyze the number of treatment sessions provided to each client. If length of time in treatment and the number of sessions have

significantly changed, then data on client characteristics should be cross-analyzed. Characteristics to be analyzed include gender, age, criminal justice referral, employment status, race, and number of treatment attempts, along with rural versus urban issues.

Changes in Client Functioning

Client data from admission, discharge, and follow-up reporting can be used to measure client functioning before and after treatment. Useful indicators of client functioning include arrests, employment, school level of functioning scales, relationships, involvement in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and hospitalizations.

Cost Off-Sets

Federal and State officials are beginning to ask whether State funding for substance abuse treatment is cost effective. One of the best ways to show that treatment can be cost effective is to identify the costs associated with substance abuse (the cost-off-sets) in such areas as health, crime, and social welfare. In looking at cost off-sets, the key components to identify are associated with client arrests, hospitalizations, and the use of welfare benefits before and after treatment.

In addition, changes in the clients' unemployment and their earned income can show a significant improvement in the tax rolls. A recent Oregon study appears to be a cost-effective way of identifying these cost offsets[2] (see *Societal Outcomes and Cost Savings Resulting from AOD Treatment,* in this issue).

Client and Provider Satisfaction

How satisfied are the clients with the managed care or substance abuse treatment program? To adequately address this area, clients need to complete a consumer survey, preferably after they have been discharged from the treatment program. This survey could examine such issues as waiting time, satisfaction with the program, and services perceived by the client as the most beneficial.

What is being proposed here is that States undertake an objective evaluation of the cost savings and the effectiveness of treatment under their new managed care or other financial arrangements. Based on these objective findings, it is imperative that decision makers be open to an ongoing adjustment of the treatment system. This process of evaluation and adjustments can lead to achieving the ultimate treatment goal — reducing the overall effect that alcohol and other drugs have on individuals, families, and the community.

[1] Gottheil, E.; McLellan, A.T.; and Druley, K.A. Length of stay, patient severity and treatment outcome: Sample data from the field of alcoholism. *Journal of Studies on Alcohol* 53(1): 69-75, 1992.

[2] Finigan, M. *Societal Outcomes and Cost Savings of Drug and Alcohol Treatment in the State of Oregon*. Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources and Governor's Council on Alcohol and Drug Abuse Programs. February 1996.

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find that decisions about AOD treatment priorities are being made by their legislatures or budget offices.

Outcomes at Different Levels

In discussing outcomes, it is important to recognize the potential for confusion. Outcomes can be addressed at six different levels:

- Individual client outcomes
- An aggregate of client-level data to measure outcomes for programs
- An aggregate of program information to measure agency or department outcomes
- A compilation of agencies' and departments' outcomes to provide system outcomes (for example, compiling outcomes from the AOD and the child welfare systems)
- Cross-system outcomes when two agencies work together to achieve common outcomes (for example, family stability may be a desired outcome of both AOD and child welfare staffs as they work together with clients.)
- Community-wide outcomes, which measure community conditions in their entirety

Progress Toward Monitoring Outcomes

Over the past few years, several States and the Federal Government have devoted considerable resources and energy to monitoring outcomes at the agency and program levels. California's investment in the California Drug and Alcohol Treatment and Assessment (CALDATA) study documented that treatment works. The 1997 National Treatment Improvement Evaluation Study (NTIES) commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) again confirmed that States and the Federal Government are meeting the challenge of being accountable for results.

The AOD field has become increasingly sophisticated about monitoring the results of our programs and documenting the cost-offsets achieved. The challenge for us now is to use this expanding information base to improve the quality of decisions made by AOD policy makers.

Balancing Health and Criminal Justice Goals for Substance Abusing Offenders

— Elizabeth A. Peyton, Bruce Fry, and the Honorable Richard S. Gebelein. Beth Peyton is a private consultant and former Director of Delaware's Treatment Access Center, a TASC program that supports a drug court. Bruce Fry is the Project Director of the CSAT Criminal Justice Treatment Networks Program, Johnson, Bassin & Shaw, Inc. Judge Gebelein is an Associate Judge of Delaware's Superior Court and former Attorney General. As chairman of the Delaware Sentencing Accountability Commission and Treatment Access Committee, he led the development of Delaware's statewide Drug Court and the effort to expand substance abuse treatment for offenders.

A significant percentage of public clients in any community are offenders with substance abuse problems. The growing acceptance of managed care raises a number of important issues concerning the treatment and control of offenders in the community. These issues need to be seen within the context of the very different outcome goals of the criminal justice and health care systems.

Managed care in the private and public health sectors has achieved prominence because of the Nation's skyrocketing health care costs. Simultaneously, crime and violence in our society have put the public increasingly at risk. The costs of crime for the Nation are staggering. We have responded with dramatic increases in jail and prison expenditures that threaten to impoverish our State and local governments. Yet we have not seriously examined how to obtain public safety in a cost-effective way.

Advantages of a Collaborative Approach

The high costs of public safety and crime are issues as important for our Nation as the quality and cost of health care. With substance-abusing offenders, these two high-cost, high-profile issues come together. Pairing health care and public safety offers a tremendous opportunity to address collaboratively the health and criminal justice issues of offenders in innovative ways. Such collaboration could create dramatic savings in public safety, crime, and health expenditures, while at the same time improving public health and safety outcomes.

This collaborative approach is necessary for success because a high percentage of substance-abusing public clients are involved with the criminal justice system. Consequently, any effective managed care program for public clients must work with the criminal justice system. Over the last 20 years, we have learned how to treat offenders more effectively by combining accountability and treatment in a completely new approach, which currently bears very little relationship to the medical model of treatment. Research has documented that the new approaches are cost effective in reducing substance abuse, crime, and recidivism. For example, a study of publicly funded clients in Oregon showed that every tax dollar spent on treatment produced $5.60 in avoided costs to the taxpayer (see *Societal Outcomes and Cost Savings from AOD Treatment,* in this issue). Most of the savings in Oregon resulted from impressive reductions in criminal activity and criminal justice costs. During the 3 years following treatment, offenders who completed residential treatment were incarcerated at a rate 70 percent lower than the matched group.

Successfully Treating Addicted Offenders

Experience suggests that the only practical, cost-effective way to treat offenders is to combine the outcome goals of the criminal justice and health care systems. This will require a substantial change in the approach and operation of both systems. It is our

Costs of Crime to U.S. Society

In 1996, annual victim losses due to crime were $450 billion, according to a report by the National Institute of Justice.[1]

- $105 billion of this total is attributed to tangible costs.
- $345 billion is attributed to reduced quality of life.

These estimates do not include:

- $40 billion per year to run the Nation's prisons, jails, and parole and probation systems.[2]
- The costs of prosecutors and the courts.

Substance abuse is pervasive among people involved in the criminal justice system. Two-thirds of arrestees in 1994 — male and female — tested positive for at least one drug.[3]

[1] Miller, T.R.; Cohen, M.A.; Wiersema, B. *Victim Costs and Consequences: A New Look*. Washington, DC: National Institute of Justice. February 1996.
[2] Butterfield, F. Survey finds that crimes cost $450 billion a year. *New York Times*. April 22, 1996.
[3] National Institute of Justice. *Drug Use Forecasting: 1994 Annual Report on Adult and Juvenile Arrestees.* Washington, DC: U.S. Department of Justice. November 1995, p. 3.

view that combining these outcome goals will result in significant improvements over all current approaches for offender treatment and public safety. In several States, criminal justice and health care professionals are beginning to collaborate to address these issues.

Any new model of collaboration needs to build on current knowledge about how best to treat criminal offenders with substance abuse problems. Over the last 20 years, thoughtful legislators and criminal justice policy makers have developed a variety of approaches that integrate a comprehensive continuum of strict accountability options with a comprehensive continuum of AOD treatment options. These programs work because they use sanctions to compel offenders to participate in treatment and hold offenders accountable for their progress. This strategy works best when it occurs within a continuum of effective, often intensive, treatment services.

Study after study has shown that this integrated approach reduces drug use, crime, and recidivism at much lower cost than traditional sanctions or treatment alone. Hundreds of programs using this approach exist around the country in a variety of forms. Such programs include drug courts, Treatment Alternatives for Safer Communities (TASC), criminal justice programs that offer intensive supervision combined with treatment, and modified treatment programs in many settings — residential, day treatment, and outpatient — that focus on offenders and stress accountability combined with treatment.

Outcome Goals of the Criminal Justice System

Public safety is now, and must remain, the top priority of judges and other criminal justice professionals. In making decisions related to offenders' sentencing, judges choose among sometimes conflicting policies, including retribution, rehabilitation, deterrence, and incapacitation. Their foremost concern, however, is whether the sentence contributes to public safety.

Some substance-abusing offenders must be placed in prison for long periods of time because of the nature of their criminal acts and their continued threat to public safety. However, a great many substance-abusing offenders can be managed safely in the community, so long as their addiction is being addressed and they are tightly supervised. For these offenders, judges perceive treatment as one part of a network of supervision, in which all components seek to ensure the offenders' recovery and end their criminal activity.

Judges will usually opt to support those treatment recommendations that are most likely to ensure public safety. The criminal justice system, when required to choose, must subordinate cost savings and cost effectiveness to the primary goal of public safety. Judges, for example, may mandate a seriously addicted offender to a residential treatment program, counting on the level of supervision to both support the offender's recovery and the public's safety.

Outcome Goals of Managed Care

As more public AOD clients are brought into managed care plans, both treatment and criminal justice professionals are concerned that we preserve and expand the existing relationships between the treatment and criminal justice systems. Outcome goals for managed care providers must be examined and adapted to meet the needs of both these systems. McGuirk and colleagues have defined managed care as "various strategies that seek to optimize the value of provided services by controlling their cost and utilization, promoting their quality, and measuring performance to ensure cost-effective outcomes.[4]

This definition is not inconsistent with the criminal justice system's primary outcome goal of public safety. At first glance, the most troubling issue may be the need for "cost-effective outcomes." However, we can redefine cost effectiveness to include criminal justice as well as health outcomes. This would make possible a dramatic shift in how we view the treatment of offenders.

Connecting Court and Managed Care Goals

The ability to reach satisfactory agreements between the courts and managed care providers is critical in any collaborative approach. Judges can choose to release offenders to community treatment programs in lieu of jail, a decision that saves considerable money. Keeping offenders in jail costs roughly $25,000 per year, versus about $15,000 for residential treatment. To meet the goal of public safety with many offenders, a judge is likely to choose treatment only when it can be combined with reliable, ongoing supervision. The requisite level of supervision may only be possible in a residential treatment program.

The judge's perspective and responsibility is in potential conflict with managed care goals. In the interest of cost-effectiveness, a managed care provider is likely to assign any client to the least intrusive treatment that might work *from a medical perspective.* This "medical necessity" criterion needs to be modified for criminal justice offenders. The factors that the managed care provider will need to consider include:

- **The needed level of ongoing supervision.** Even *intensive* outpatient treatment programs, for example, cannot provide the level of supervision available in a residential treatment program.

- **The chronic nature of addiction.** A pattern of relapses is typical for recovering clients. Addicted offenders, in particular, need to be eligible for repeated courses of treatment.

- **The needed scope of ancillary services.** Drug-involved offenders typically have many social and behavioral deficits. These deficits need to be addressed, in addition to the substance abuse, or the client may not have the personal and social resources to maintain recovery.

Integrating Goals and Outcomes

Properly designed managed care systems should improve effectiveness and reduce costs associated with appropriate treatment for offenders. However, a proper design will mean significant changes in how we currently administer managed care. It will also mean change in some fundamental assumptions and operating principles associated with managed care as it exists today. The following changes are worth considering.

- **Expand participation in system development**. At both the policy and service delivery levels, criminal justice professionals need to be included as equal partners with the health care system. Those who should be included are State officials representing corrections, parole, the judiciary, State police, and the attorney general; local professionals, such as judges, prosecutors, probation officers, defense attorneys, sheriffs, and police; representatives of victims' groups; and providers who specialize in treating offenders. Criminal justice representatives need to be included at every decision point, not simply in an advisory capacity, but as equal partners in the conceptualization, design, implementation, and operation of managed care systems for substance-abusing offenders. The criminal justice system can be a powerful ally to ensure that public clients get appropriate services.

- **Increase funding**. If the criminal justice system wants to be an equal partner in shaping and controlling how offenders are treated, then it must dramatically increase the treatment funding it provides. Numerous studies show that treatment reduces criminal justice costs. Criminal justice professionals need to shift resources from prosecutors, courts, and incarceration to treatment, or to request that State legislatures provide more funding for treatment.

- **Modify system designs**. To provide effective care for offenders, contracts written with managed care organizations (MCOs) and other agencies must specify that a variety of services will be provided. These services will integrate a comprehensive continuum of strict accountability options with a comprehensive continuum of AOD treatment options. This reflects our knowledge that the most effective approach is to provide a continuum of both treatment and accountability from the point of arrest through the period of incarceration, probation, and parole. Obviously, funding and management mechanisms for providing treatment should mirror this path whenever possible.

  This approach would require an unprecedented degree of cooperation among MCOs and criminal justice and treatment agencies. To provide the results we desire, the criminal justice and health systems need to develop formal working relationships, including the pooling of funds and shared decision making.

- **Reward improved outcomes**. Regardless of the organizational structure, contracts must be written so that MCOs are rewarded for improved criminal justice outcomes. This reward structure can be made possible through the joint participation and funding of county and State criminal justice agencies, along with substance abuse agencies. This reward structure acknowledges that positive criminal justice outcomes create large, real-dollar savings for law enforcement, court and penal systems, and taxpayers. These outcomes include reduced criminal activity, fewer violent and nonviolent crime victims, reduced recidivism, and an increased sense of safety and well-being for our citizens.

If we cannot modify the present generation of MCOs to serve both criminal justice and treatment goals effectively, it may be necessary to carve out plans that separate substance-abusing individuals involved in the criminal justice system from other populations. Under this scenario, an offender-dedicated provider network would serve clients from the point of arrest through incarceration and/or probation or parole.

This carve-out approach assumes that criminal justice and treatment agencies will jointly operate and fund the system. This may be the most viable option if current approaches are unable to address the goals of the criminal justice system adequately or to reduce the huge social costs of criminal acts by substance abusers.

Although there are areas of potential conflict between criminal justice system goals and managed care for public clients, there are also many opportunities for achieving mutual goals. Both systems are interested in cost-effective and efficient service delivery, and both systems strive for effective outcomes. The challenge now is to bring both systems together and create a broader vision that will combine the interests of both, resulting in safer communities for everyone and improved health for clients.

[1]Miller, T.R.; Cohen, M.A.; Wiersema, B. *Victim Costs and Consequences: A New Look*. Washington, DC: National Institute of Justice. February 1996.

[2]Butterfield, F. Survey finds that crimes cost $450 billion a year. *New York Times*. April 22, 1996.

[3]National Institute of Justice. *Drug Use Forecasting: 1994 Annual Report on Adult and Juvenile Arrestees.* Washington, DC: U.S. Department of Justice. November 1995, p.3.

[4]McGuirk, F.D.; Keller, A.B.; and Croze, C. *Blueprints for Managed Care: Mental Healthcare Concepts and Structure*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, May 1995, p. 66.

Managing Care to Improve Treatment Outcomes for Offender Populations

— Melody M. Heaps, President, Treatment Alternatives for Safer Communities (TASC), Chicago, Illinois

The tremendous volume of drug- and alcohol-addicted offenders throughout the country is overwhelming courts and correctional systems, as well as the substance abuse treatment and acute health care systems. Our criminal justice system has become a magnet for poor, severely addicted offenders who commit a large number of drug-related crimes to support their habits. Without treatment, these offenders keep recycling through the system. In addition, their presence impedes the criminal justice system's ability to manage violent and high-risk offenders effectively. Criminal justice officials across the country are increasingly aware of these issues and of the effectiveness of treatment. They are referring growing numbers of offenders to alcohol and other drug (AOD) treatment. Meanwhile, treatment resources for publicly funded clients are increasingly scarce.

Limits of Managed Care in Handling Offenders

Many States, operating with limited resources, have contracted with private managed care organizations to treat publicly funded substance abuse clients, including offenders referred through the courts. However, commercial managed care companies are inexperienced at dealing with the complex range of problems typical of this population and are unfamiliar with the needs of the referring criminal justice system. Because of their inexperience, these commercial companies have proven inadequate to the task of managing the substance abuse treatment of offenders. This task involves maximizing treatment outcomes while also meeting justice system requirements.

Unlike the privately insured alcoholics or drug-dependent clients with whom managed care companies have worked in the past, substance-abusing criminal offenders are likely to have issues of mental illness, poor health, inadequate housing and food, lack of available child care, absence of family support networks, and other problems. These offenders' ability to succeed in treatment will be tied to how successfully their life issues are addressed by the person managing their care.

States confront a difficult dilemma. They must effectively address the criminal justice system's need to place large numbers of offenders in treatment, while they also face the reality of limited resources. One solution is for States to consider using a specialized, comprehensive managed care system for criminal offenders. Such a system could blend state-of-the-art managed care tools, such as utilization management and resource allocation, with an ability to meet the requirements of the criminal justice and treatment systems.

Principles for Managing Treatment of Offenders

Illinois TASC has been a manager of behavioral health care for substance-abusing offender populations since 1976. Based on this experience, Illinois TASC advocates for certain managed care principles that we believe would improve treatment outcomes for offenders.

It is important to understand that placing offenders in treatment and managing their care can occur at a variety of points in the criminal justice/corrections continuum. Placement in treatment provides different advantages at different stages. When used as part of the court adjudication process, treatment programs move substance abusers out of crowded local jails more quickly and, through expedited processing, allow judges to spend time on more serious cases.

When offenders who would otherwise be sentenced to State correctional facilities go to treatment instead, this frees up resources that can be directed at violent and high-risk offenders. Managed treatment can also be used to improve the safety and effectiveness of early release and parole systems.

Principle #1: Prioritize the population. Establishing priorities is essential in this period of limited treatment resources, when the criminal justice and treatment systems each have their own specific goals. Drug-dependent people in need of rehabilitative services far exceed the resources available to treat them, and unless the system is managed effectively, offenders may utilize a disproportionate amount of treatment resources. Prioritizing should be based on:

- The *resources that can be saved* by virtue of the participant's successful rehabilitation
- The criminal justice system's *ability to apply coercion* for a participant to enter and stay in treatment
- The individual's *clinical need for services*

The prioritizing stage also offers the chance to evaluate ancillary service needs, which significantly affect the offender's likelihood of successful recovery. Examples of those with ancillary needs are pregnant women who require prenatal care as well as addiction services, women with children who require treatment placements that include day care, and clients with a dual diagnosis of substance abuse and major mental illness.

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Performance-Based Monitoring in Narcotic Addiction Treatment

— Dorynne Czechowicz, M.D., National Institute on Drug Abuse (NIDA); Laura Graham, M.P.A., Quintiles, Inc.; and Bill Luckey, Ph.D., Research Triangle Institute (RTI)

Narcotic addiction treatment is a vital component of the national effort to reduce opioid and injection drug use and its consequences. The quality and outcomes of narcotic addiction treatment are, therefore, of great importance to the alcohol and other drug (AOD) abuse treatment field. A performance-based measurement system in narcotic addiction treatment programs has the potential to help clinics improve the services they deliver to their patients.

The National Institute on Drug Abuse/ National Institutes of Health (NIDA/ NIH) is funding a study called the Methadone Treatment Quality Assurance System (MTQAS) that is designed to determine the feasibility and usefulness of a performance-based feedback system for narcotic addiction treatment programs. The study is being conducted by the Research Triangle Institute (RTI) in collaboration with the Center for Substance Abuse Treatment (CSAT) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Focus on Quality

Treatment program staff are concerned with quality improvement. In addition, managed care entities and payers are increasingly interested in managing costs and quality for the purpose of achieving optimal value for the dollars spent and services provided. Though many measurement, data management, and reporting methods and tools were developed for the primary health care field, they are just now being used by the substance abuse treatment field.

In assessing quality, one challenge has been how to define and identify appropriate indicators of quality improvement. Performance indicators are most useful if they are defined and measurable, can be tracked over time, and accurately reflect the treatment process.

MTQAS is designed as an outcomes-based monitoring system that tracks program performance over time based on patient outcomes. Phase I of MTQAS, which ended in July 1995, focused on designing the system and testing a prototype for a limited time in a relatively small number of clinics. Phase II is a full-scale assessment of the feedback system in which many narcotic addiction treatment clinics in seven States participated. Data collection began in 1996 and continued through 1998. Study staff are analyzing both quantitative and qualitative data to understand what is required to implement and operate such a system and to determine how programs and States use the information.

Phase I: Defining Indicators

Phase I of MTQAS answered several key questions:

- Which performance indicators, including treatment outcomes, can usefully serve as the basis for a performance measurement system? This system must be capable of comparing client outcomes fairly across clinics by adjusting for a program's "case-mix" (that is, by separating the contribution of client characteristics from the program's performance).

- How might performance feedback be structured so that it provides the greatest assistance to clinics? What operational problems might arise if such a system were implemented?

In devising a strategy to answer these questions, MTQAS staff consulted an advisory panel of providers, researchers, quality assurance experts, representatives from national health professional organizations, and Federal agency representatives. Staff then developed a client-level data collection instrument (Client Assessment Profile or CAP) that was field tested in Phase I. The first part of the field test was conducted in five narcotic addiction treatment clinics. Based on inter-rater reliability tests and clinician ratings, the items in the CAP proved to have both high validity and reliability.

The second part of the field test involved a controlled 6-month test of the performance reporting system in 25 narcotic addiction treatment clinics in 16 States and the District of Columbia. Program staff collected data on approximately 1,200 patients and provided one feedback report to each participating clinic. The feedback report contained descriptive data about each program's patients and, based on case-mixed data, provided quintile ranks for each outcome. MTQAS staff met with program directors to obtain feedback about their experience participating in MTQAS and about the usefulness of the information provided to them.

Phase I Findings

Phase I resulted in good information about which outcomes form the basis for a performance monitoring system and which patient-level information is necessary to case-mix the data. Additionally, the Phase I program directors had a significant impact on the structure of Phase II, particularly the operational issues associated with MTQAS and the structure and format of the performance feedback.

Phase II: Testing the System

Phase II was a full-scale assessment of the MTQAS system. Phase II's goals were to:

- Determine whether a performance-based system can be implemented in narcotic addiction treatment clinics on an *ongoing* basis and identify any operational problems with such a system.
- Assess whether performance feedback — either alone or in combination with technical assistance — can be used to guide changes in clinic processes or procedures that will enhance the quality of care provided.
- Assess the efficacy of the MTQAS system for improving selected in-treatment outcomes (that is, outcomes that should be rapidly influenced by relatively minor changes in clinical protocols, such as dosing policies).

MTQAS Phase II was innovative for several reasons. First, Phase II was implemented in 7 States and approximately 80 clinics, over a third of which were private. Nearly 80 percent of clinics in the States participated to some degree. Second, the study involved a partnership among providers, the States, and the research community. Clinic staff collected intake and quarterly follow-up information on all patients in narcotic addiction treatment over a period of 18 months. Each State processed the data as it was received from its clinics, and sent a data file to RTI for analysis and production of the Quarterly Performance Feedback Reports. Finally, CSAT provided technical assistance to a sample of the participating clinics whose outcomes were below expectations.

The MTQAS study design allowed for comparisons across clinics, across funding and regulatory environments, and across time. Seven States participated: Arizona, Colorado, Georgia, Massachusetts, North Carolina, Pennsylvania, and Washington. MTQAS was implemented statewide in each, in both public and private clinics. Pennsylvania had some difficulty implementing this approach because of changes in the public health care system, and eventually discontinued data collection. Reassessments were ongoing, with quarterly performance feedback reports provided to the clinics. Ten clinics also received technical assistance (TA) through CSAT to translate the MTQAS feedback into action. A standardized, on-site assessment was conducted at clinics selected for TA by an experienced narcotic addiction treatment provider to develop the TA plan. The TA delivery occurred in early 1998.

The MTQAS study fostered discussion among the narcotic addiction clinics, State offices, CSAT, NIDA, and the research community. Such communication is important to determine how the performance-based outcome information can best be used for improving the quality of narcotic addiction treatment.

In addition to producing the feedback reports, RTI staff also assessed the implementation of MTQAS through quarterly calls to State staff. RTI staff were interested in learning what challenges were encountered and how they were being addressed during the MTQAS implementation. Study staff are to visit each of the States at the conclusion of the study to meet with providers and State staff. These meetings are designed to obtain a better understanding of what it took to implement MTQAS, the usefulness of the feedback reports, including both the value and limitations of the information, and how the system might be improved.

Description of MTQAS Assessments

The performance feedback reports were based on patient-level data collected by clinic staff. Most items necessary for the performance feedback reports were items that a clinician would ask as part of a routine assessment. The experience in Phase I demonstrated that if MTQAS were to be successful, the system needed to be embedded within clinic operations. Clinics sent their data to their State office, which acted as a clearinghouse for the data. In each State office, a contact person was responsible for shipping the data to RTI on a monthly basis. The MTQAS assessment schedule for each patient included the following:

- **An initial assessment.** This contained the key pieces of information to provide baseline measures for outcomes, as well as other patient characteristics that were used to adjust for differences in the types of patients served when making comparisons across participating clinics (that is, the case-mix adjustment). MTQAS staff selected these items on the basis of previous research, including Phase I of MTQAS. The initial assessment, completed at admission, took no more than 10 minutes.
- **Periodic reassessments.** These included items based on interviews, as well as items recorded from the patient record. These follow-up items were required for the outcome analyses and included in-treatment behaviors, such as drug use, injecting behavior, arrests, and urinalysis results. These measures were commonly applied to drug treatment outcomes. The measures were also useful for a counselor to ask and observe during regular treatment plan reviews. Actual timing of the periodic reassessments was determined for each patient according to the date of admission. Reassessments were conducted on a quarterly basis for patients who had been in treatment less than 1 year ("shorter term") and biannually for patients who had been in treatment more than 1 year ("longer term"). The periodic reassessments, includ-

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Societal Outcomes and Cost Savings from AOD Treatment

— Jeffrey N. Kushner, Drug Court Administrator for the 22nd Judicial Circuit, St. Louis, Missouri, and former Director, Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources.

Most State legislatures are not convinced about the "goodness" of alcohol and other drug (AOD) treatment by reviewing either national research data or studies completed in other States. State legislatures want data from the State treatment system they are funding. This can be a problem from several standpoints, not the least of which is the onerous cost of follow-up studies that depend on personal interviews. And how accurate are they, really?

Over the past 30 years, there have been a number of studies involving economic analyses of the benefits and costs of drug and/or alcohol treatment.[1] The usefulness of their results has often been weakened by limitations in their methodologies. These study limitations include the following:

- Lack of a comparison or control group
- Failure to use a representative sampling design in selecting subjects
- Exclusive use of self-reported data
- Brief observation periods (usually focused on the time just before or just after treatment — not necessarily representative periods)
- Use of limited populations (for example, enrollees in an HMO)
- Assessment of costs and benefits only in a limited number of areas

Oregon's Study Approach

Oregon decided to take a different approach. A study that would use Oregon-specific outcome data was chosen as a result of interest from the Governor's Council on Alcohol and Drug Abuse Programs and a nudge from the Oregon Legislative Assembly. The total cost of this study was approximately $30,000. No specific funding was provided.

The Oregon study was designed to overcome some of the methodological limitations of prior studies that have looked at benefits and costs of drug and/or alcohol treatment. Its study design has the following characteristics:

- We selected a representative sample of clients who had completed treatment and matched them with a comparison group of clients who received little or no treatment.
- We used existing State agency databases rather than self-report data; these databases provided for maximum objectivity.
- We utilized an adequate study period, which covered 2 years prior to treatment and 3 years subsequent to the completion of treatment.

Study Design

Using a quasi-experimental design, groups of clients who had completed treatment were compared with groups of clients who had enrolled in treatment programs but terminated after receiving only minimal services. In order to have up to 3 years of post-treatment outcome data, the sample was drawn from fiscal year 1991-92.

Using the Client Process Monitoring System (CPMS) database, a representative random sample of clients was selected for each service element — outpatient, residential, and methadone. The CPMS database is the Oregon management information system for alcohol and/or drug treatment programs that receive public funds (built off the old CODAP system). Programs must report on clients at intake and at termination.

A comparison group was randomly selected. This group was made up of clients who began treatment but did not follow through in keeping appointments. The comparison group was matched to the treatment completers, so that no differences existed between the groups in age, gender, race, drug type, or severity of drug abuse. Based on a power analysis of the needed sample size, we set a target of 250 treatment and 250 comparison clients for each module, outpatient and residential. A total of 1,267 clients was originally selected for the study sample.

Use of Existing Databases

To collect outcome data for these clients from the periods prior and subsequent to their treatment episodes, we used existing State databases. We gained permission to access these databases and protected the confidentiality of clients at all times. These State databases included the following:

- Client Process Monitoring System
- Law Enforcement Data System
- Offender Profile System
- Adult and Family Services
- Office of Medical Assistance Programs (Medicaid)
- Children's Services Division

Outcome Study Results

Oregon's study found extensive cost savings on a variety of dimensions for clients who had successfully completed their AOD treatment. Significant cost savings occurred because of the reductions in arrests and convictions, incarceration, use of welfare benefits, open child welfare cases, emergency room medical costs, and because of an improvement in clients' earning power and number of days worked. For every dollar spent on treatment, taxpayers saved $5.60 in avoided costs.

Even this figure is most conservative for the following reasons:

- The study includes no cost savings from the clients' decrease in unemployment.
- Some benefit can be assumed to accrue for those comparison-group clients who were treated for weeks and/or months but did not complete treatment. These savings are not represented in this study.
- Other potential cost avoidances are not included. For example, savings were realized because many clients avoided problems that would otherwise have exacted public and private funds, such as Federal and local prison costs, institutional costs, damage caused by intoxicated drivers, business losses, and the birth of healthy rather than drug-affected babies.

Copies of the study *Societal Outcomes and Cost Savings of Drug and Alcohol Treatment in the State of Oregon* are available from the Oregon Office of Alcohol and Drug Abuse Programs. To order, call Clint Goff, at (503) 945-5763.

[1]For a thorough examination of all but the most recent research, the reader is referred to: President's Commission on Model State Drug Laws, *Socioeconomic Evaluations of Addictions Treatment,* by the Center of Alcohol Studies at Rutgers University. The White House: Washington, DC, 1993.

Results of Oregon's State-Specific Outcome Study

- AOD treatment completers had significantly fewer arrests and convictions in the 3 years after treatment than early leavers, even though there were no statistically significant differences in their arrest and conviction histories prior to treatment. Clients who completed outpatient treatment were arrested at a rate 45 percent lower than the matched group.
- Treatment completion is associated with substantially fewer incarcerations in State prison and with shorter incarcerations. Clients who completed residential treatment were jailed at a 70 percent lower rate than the matched group.
- Treatment completers earned 65 percent more than noncompleters, due to higher wages and increased time at work.
- Clients who completed treatment reduced their use of food stamps by one third in contrast to the comparison group.
- For clients who completed treatment, the number of open child welfare cases decreased by 50 percent.
- Medical expenses dropped substantially for treatment completers compared with the control group. Early leavers dramatically increased their use of hospital emergency rooms.
- Savings of $83,147,187 in avoided criminal justice, medical, and public assistance costs, and in victim and theft losses were realized for the 1991–92 cohort of treatment completers in the 2½ years following treatment. The cost for AOD treatment for all adults in 1991–92 was $14,879,128.
- Overall, significant positive societal outcomes resulting from AOD treatment accrued and lasted for at least 3 years.

Performance-Based Monitoring in Narcotic Addiction Treatment

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ing completing the record data, took approximately 10 minutes per patient.

- **Client profile.** Five items on client demographics were collected one time only from patients already in treatment when the MTQAS data collection began. These five items were necessary for the minimal case-mix adjustment methods.
- **Client discharge.** The discharge information collected included the date and reason for discharge. This information, extracted from the patient record, was completed when a patient left a clinic.

The Case-Mix Adjustment Process

One important reason that outcomes may differ across clinics is that clinics serve different types of patients. Case-mix adjustment is a way of leveling the playing field when comparing outcomes across clinics that have different patient populations.

Case-mix adjustment is used to look at patient outcomes in a wide range of service settings: hospitals, nursing homes, home health agencies, ambulatory care settings, and mental health clinics. In MTQAS, this process was used to adjust for different patient populations when comparing or ranking clinics according to their patients' outcomes.

Case-mix adjustment involves a statistical analysis in which patient characteristics and baseline behaviors are used to predict patient outcomes. For each outcome, a different statistical model is used. For example, one of the outcomes is "no arrests." How well each clinic does on this outcome is estimated, while adjusting for a number of factors that may affect patients' arrest rates. These factors include patients' age, gender, race, current criminal justice status, and arrest history.

MTQAS Indicators/Outcomes

MTQAS used a variety of outcomes as part of the performance reporting system. An important part of the study's

development was determining which outcomes would be most appropriate to include in a performance feedback system. The MTQAS outcomes included self-reported drug-using behaviors and results from urine tests, as well as social functioning, physical and mental health, utilization of medical services, the patient's satisfaction with services, and retention in treatment. MTQAS staff selected these outcomes on the basis of MTQAS Phase I results, discussions with the participating State staff and advisory panel members, and a review of pertinent literature. Indicators were selected for the core MTQAS data set. In addition to this core set of outcomes, many States have opted to add other items to their data set. These include HIV-risk behaviors, social support, and the use of other drugs, such as methamphetamine and alcohol.

Application of MTQAS to Other Treatment Modalities

Although MTQAS has been developed for and is being tested in narcotic addiction treatment clinics, many of this system's attributes make it applicable to other treatment modalities. This new system provides data on measurable outcomes, tracks performance over time, and uses indicators related to the treatment process. Furthermore, some of the outcomes are associated with changes in costs and may be useful in a cost-offset model.

The indicators used in MTQAS are likely to be valuable both internally to clinic staff and externally to payers and patients. MTQAS will assist the treatment field in determining how best to implement a performance-based system and how the feedback may be used to implement changes in clinic practices.

Managing Care to Improve Treatment Outcomes for Offender Populations

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Principle #2: Designate resources that are geared to priority populations. Criminal offenders who have been mandated by the court are, by and large, reluctant treatment participants. Offenders often see treatment primarily as a way of avoiding incarceration, not as a mode for changing their behavior or lives. At least initially, offenders may participate in treatment as a condition of release and to avoid the criminal court sanctions that would be imposed for failure to comply. These external incentives and sanctions can be used to improve treatment outcomes. The length of time offenders spend in substance abuse treatment has been shown to be a decisive factor in positive treatment outcomes. A managed care plan geared to the offender population can offer definite advantages by linking sanctions with treatment. The criminal justice system's hold over offenders can be linked to the level and length of treatment best suited for each individual.

A number of criteria can assist in making appropriate decisions about placement in treatment and the level of case management necessary. The following factors need to be evaluated:

- The nature, extent, and duration of the offender's substance abuse
- The nature of an offender's criminal history
- Whether there is a compulsive component to the crimes, with some level of calculated criminality. Such criminal behavior patterns will fall along a continuum.
- The relationship between the individual's criminality and substance abuse

This evaluation allows the most intensive and costly modes of treatment — residential and intensive outpatient — to be employed only for those who actually need it, rather than expending intensive services on people whose addictions can be addressed in less restrictive environments.

Principle #3: Provide ongoing management of resources. All the issues identified under the first two principles remain in play throughout the course of treatment and supervision — from initial screening to the conclusion of the offender's involvement with the criminal justice and treatment systems. To ensure appropriate allocation of treatment resources, there must be continued utilization management, monitoring of criminal justice risk and status, and ongoing evaluation of clinical levels of care.

The 20-year experience of Illinois TASC demonstrates that it *is* possible for specialized managed care to enhance treatment success rates with offenders. This can happen with limited resources, if those resources are applied wisely and efficiently. Many TASC organizations around the country already have years of experience at simultaneously addressing the legal requirements of courts, the procedural standards of treatment providers, and the clinical needs of offenders. TASC organizations are poised to move into the management of substance abuse treatment for the offender population. To expand services, it would also be possible to involve other social service organizations that have staff with experience working in the criminal justice arena.

Designing Information Systems for Outcomes-Based Services

— Robert S. Mirel, M.S.W., Systems Resource Group, Inc., Bala Cynwyd, Pennsylvania.

A great deal of effort has gone into designing and implementing information systems for public-sector organizations that provide human services. This is occurring during a time of sweeping change in the delivery and evaluation of services. With the ever-shrinking pool of available resources for public-sector programs, funding authorities and other purchasers are seeking providers who can ensure cost effectiveness and high quality services, as measured by successful outcomes.

Providers are in demand who can offer strong management and the tools to identify critical issues and to implement new strategies on a timely basis. The emphasis on outcomes has placed a significant burden on service providers, who need to implement changes in their organizations to achieve the required level of outcome information. Providers are looking to modern, sophisticated automated information systems for support in this new arena. Computerized information systems are a needed tool to make these changes effectively and efficiently, to show purchasers the capabilities of the provider organization, and to maintain a program's effectiveness over time.

The Shift in Demands for Data

AOD organizations have been operating in an environment that emphasizes involving people in treatment services, on the assumption that treatment would provide the support needed to improve their quality of life. Now, these organizations are being asked to show very specifically the value of those services in observable and measurable ways. In fact, organizations are being asked to identify, in quantifiable terms, what treatment works with persons who present with very specific diagnoses.

To complicate this further, many organizations that serve multiple purchasers are being asked to provide different information to each. This is particularly difficult for most public-sector providers. Traditionally, publicly funded programs have had few resources to dedicate to the development of automated information systems. In addition, these programs have not focused on measuring individual client outcomes.

The current shift to a person-centered approach has forced many service providers to re-examine the way they do business. This approach requires a new means of managing complex organizations. Collaboration among departments that provide various service supports has had to be expanded and, in many cases, newly developed. Providers are growing substantially more reliant on their administrative and financial departments.

A person-centered approach requires the development of information systems that are both comprehensive and integrated. Only a comprehensive information system is capable of giving the provider what is needed — a complete view of a client's needs, of the services being provided, and the cost of those services. An information system also gives a provider the ability to utilize that information on a timely basis to ensure desired outcomes.

Benefits of a Comprehensive System

A comprehensive and integrated information system creates significant benefits for the organization using it. The structure that is built to support this system will hold data from many areas of the agency. Such a system:

- Allows for easier access to the data needed to support complex analyses. This single computer environment maintains data from every department in the agency.
- Allows for more timely reporting of information, since all data is active and available in the system at the same time. There is no need to import or transmit data to or from other departments.
- Supports reporting to many different sources. Data can be combined and calculated within the structure available without requiring assembly from any external source.
- Supports efficient management of the system.
- Supports more secure and effective modifications to the system when necessary.
- Reduces training time and costs.

Designing Systems for Today's Environment

In today's environment, it is a challenge to design automated systems that can meet the many varied needs of the complex organizations providing behavioral health services. System development has become much easier with the advent of less expensive computer systems. In addition, many tools are now available for developing software that can respond to complex design criteria. The design of these automated systems is still quite complex and requires the cooperation of the entire organization. As organizations change and grow in this new environment, they need to be able to build clinical, administrative, and financial systems that will also grow and change. Information systems can and must be designed to meet changes as they emerge.

Staff role in designing information systems

Today, the outcomes to be measured are a critical component in developing an information system for an organization. The organization must clearly define what is to be measured. Defin-

ing which measures are to be used, and how these measures are best defined in terms of data to be collected, presents a difficult set of issues for the organization. Key staff from each department need to participate in this effort. Each department's staff may need to provide basic orientation to those from other departments. The issues and concerns of each can then be mutually appreciated and understood in terms of their impact on client outcomes.

The task for the provider organization staff is to define key indicators. When these indicators are analyzed and examined by professional staff, they will help identify outcomes. Program staff need to define each of the outcome indicators in terms that are relevant to the way in which they serve people. As they do this, staff must identify what data needs to be collected and/or derived throughout the process of providing service.

Role of information system professionals

Meanwhile, the information system professional's task is to define methodologies that will support this effort. These methodologies need to closely match the operational environment of the organization. Once staff have identified the data needed, the systems person can incorporate these elements into the data system and define the relationship between the different data elements. This data system will then support the processing of information that can produce the desired types of analyses for staff interpretation.

This systems development process means close cooperation among the agency's professional staff and the information system professionals. The agency staff needs to understand the purpose of the system and to get value-added information from it. Only then will the information system provide substantial support to professional staff in their daily work.

Meeting Agency Needs First

The introduction of this type of comprehensive, staff-driven information system brings about significant cultural change in an organization. To gain staff acceptance, it is critical that the information system be designed and built for that particular agency's staff. The system can provide functions that are specially designed to be useful and to meet the needs of staff from each department. When system interfaces are designed to meet specific departmental staff needs, then the system has built-in momentum toward acceptance and can be effectively integrated into the environment of the organization. When a system is developed with data collection and reporting features that closely match the needs of those who use it and the way in which they work, data will often be better and the system will be used more effectively.

Organizations need to be clear on one point. The primary focus of the information system is to serve and meet the needs of the organization that will be using it — whether that organization is a provider, a governmental jurisdiction, or a managed care organization that is purchasing services. The data being collected, as well as the method of collection, should be defined in terms that best reflect the goals of the agency. This organization alone can effectively define how that data is to be processed into information and how that information is to be portrayed to users of a system.

It is the organization's needs that should be paramount, not those of other organizations that require reporting. Reporting to outside entities can be accomplished effectively by making adaptations to automated systems. For example, reporting needs can be incorporated into an overall automated system by adding data elements or support for reports/analyses that were not otherwise defined. Often this does not require substantial modification to the system design.

Meeting Needs of Outside Sources

At the time an information system is being developed to meet the many and varied needs of constituencies within an organization, that system can also be designed to meet the requirements of any outside entities. Often, organizations aim to design systems that will meet specialized needs. Then, when a new need comes along, an entirely new system is developed. This piecemeal approach can lead to substantial inefficiencies and confusion on the part of staff. Importantly, a too specialized approach is not likely to provide the information that will be needed for the effective management of the organization.

An effective way to deal with this issue is to develop comprehensive and integrated information systems that are flexible and designed to grow and change. As an example, programs funded to demonstrate the effectiveness of new programmatic initiatives are often required to develop information systems. These systems are required to provide funding sources with specific feedback on the operation of the project. The Federal government often sponsors projects that require such information systems.

Local programs and jurisdictions take varied approaches to meeting these requirements. Some organizations design systems that specifically meet the need identified by the funding source. Others use this as an opportunity to meet their own agency or jurisdiction's long-term goals. They develop an information system capacity that will primarily serve the goals and objectives of the jurisdiction, while also incorporating requirements of the funding source. This second approach is the more productive and promising for any organization intent on developing or upgrading their automated system.

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